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The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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EARLE H. HUNT, M. D.

Clarksville

PRESIDENT

Arkansas Medical Society

1950-1951

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The JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL
Vol. XLVII FORT SMITH, ARKANSAS, JUNE, 1950 No. 1

PRESIDENT'S ADDRESS*

EUCLID M. SMITH
Hot Springs National Park

It has been a great honor and a happy privilege to serve as your president during the past year. It has been a busy year, and I feel that we have accomplished a great deal due to the wonderful help and cooperation of the entire membership of this organization. I am especially indebted to our past-president, Dr. P. W. Lutterloh, and to our president-elect, Dr. Earle Hunt. In spite of the difficulties associated with the reorganization of the various committees, they have all done a splendid job. The Woman's Auxiliary has made an outstanding contribution this year; we especially appreciate their fine efforts.

I also want to call to your attention the splendid cooperation we have had from the Arkansas Congressional delegation. In our fight against Reorganization Bill No. 1, our delegation gave us unanimous support. I particularly want to emphasize the fine help given by Senators Bill Fulbright and John McClellan and by Dr. R. B. Robins of Camden.

We have had splendid help and cooperation from various other organizations in the state, the Arkansas Dental Society, the Chambers of Commerce, Arkansas Free Enterprise Association, and the Arkansas Public Expenditure Council, under the able leadership of Mr. Sam Hays.

We are especially indebted to the Agricultural Extension Service of the University of Arkansas for their fine help and cooperation with our rural health committee. I wish to make public acknowledgment of our appreciation to Mr. Aubrey Gates and Miss Helen Robinson. Again the nation has looked to Arkansas for leadership. The University of Arkansas has loaned Mr. Gates to the Rural Health Council of the American Medical Association. Mr. Gates is especially fitted for this important position.

We have achieved many of our objectives during the past year, but now is the time for organized medicine to show its strength as never before.

The House of Delegates of the American Medical Association, as you know, at the recommendation of the Board of Trustees, fixed or levied dues on each member in the Association at $25 for 1950. This was the first time that dues have been charged to members of the Association. Prior to this time a member of a state association was automatically a member of the American Medical Association without payment of dues.

Last year we were assessed $25 by the Board of Trustees to inaugurate an educational campaign to bring medicine's message to the American people. We have executed a successful program and money is needed to complete our job. At no time in the history of medicine in this country has unstinted support been so necessary. Failure to pay dues only increases the enemy's strength. If, at the end of 1950, we should have only 60,000 doctors who are members of the American Medical Association, our enemies could well say that the doctors don't even believe in their own cause. It is our desire to see this state have one hundred per cent membership in the American Medical Association.

Likewise, dues have been raised in the Arkansas Medical Society to meet the increased cost of the business side of the organization. Our funds have been spent to broaden the activities of the Council, the Public Relations Committee, the Woman's Auxiliary, and the office of the Executive Secretary. Without funds, we cannot develop an aggressive organization nor can we develop a program which will strengthen the faith of the people in medical leadership.

So many times we are asked: "Why doesn't the medical profession come out with a positive program instead of always being against proposals?" The American Medical Association has its twelve-point program which it is developing and implementing as rapidly and soundly as possible. Now what can we do here in Arkansas to supplement the national effort? I believe the Community Health Councils offer us one of the best

*Read before the 74th Annual Session, Arkansas Medical Society, Fort Smith, April 17, 1950.

media for exhibiting our intent to improve the health care of our people. The Arkansas Medical Society recognizes its responsibility for providing leadership in assuring constant improvement in the health of the people of Arkansas.

Support of the medical profession of any community health program is essential to success since its prestige lends confidence to the program. One must not lose sight of the fact that a Health Council is a community-wide project and is not to serve the selfish motives of any particular agency or group, nor can it be dominated by any person, agency, or group. On the other hand, because the medical profession is in a strategic position to assume leadership in health matters, the local medical society should play a prominent part in the initiating and conduction of Council activities. Each community should develop what it wants and needs; it should change policies and programs to fit changing requirements. Through cooperative effort the physicians and lay groups who make up a community will attain far greater health goals than could be attained by either group working alone. If a Health Council has not already been formed, the local medical society should take the initiative and call together community leaders and local organization representatives to form a Community Health Council. If a Health Council is already functioning, it behooves the county medical society to participate generously in its activities.

Rural health problems are a vital portion of our extension of medical services. The major elements of the problem are three-fold: first, the education of farm groups concerning health needs; second, the furnishing of adequate medical service through placement of doctors in rural areas; third, the extension of health services at lower costs through both voluntary health insurance and community health councils.

Under our present program of education, farm groups are increasingly aware of their medical needs. Individual communities, however, must be made to realize that they have a responsibility too, in the acquisition of better health services. Through development of a placement bureau, communities and prospective rural practitioners should be able to meet and solve their problems —on the one hand, the community making agreements to have quarters and economic support available for physicians; and physician's recognition of the responsibility for medical care for his community.

Development of the medical center is of consuming interest to all of the doctors of this state. The successful accomplishment of this center offers a new level of education for students as well as an increased outlet of medical benefits to all of the people of this state. Without the wholehearted support of all doctors throughout Arkansas, this project cannot succeed. A committee of doctors from this Society becomes a necessity —first, as an expression of our complete desire to cooperate in the solution of the medical needs of our state; and, second, to advise and supervise the level of education and the disbursement of medical care. Membership on such a liaison committee should be long-term, to allow greater familiarization with the problems of the center and consequently a more mature settlement of such problems.

A vital portion of the medical center naturally will be the incorporation of the State Hospital for Nervous Diseases. The proposed plans will lend added facilities and advantages of inestimable value to the State Hospital. An institution of this type, as a part of a major teaching facility, will at once advance its status in the level of patient care and at the same time, serve as an effective mechanism in the instruction of students.

However, it becomes of such importance to support the medical center that every doctor within this Society should be intimately and individually concerned with its construction and the realization of its aims. Without such complete cooperation, our efforts become ineffective, with resultant inefficiency and incompetence.

The activities of the State Board of Health are of such importance in bringing better health to our people that all support possible should be given to this organization. In order that local units of government might provide their proportionate share of the expense in conducting a local health program, there needs to be a provision made for them to vote a millage specifically for public health purposes. Their need for increased salaries for public health personnel in this state has long been felt. It is our duty to see that provisions are made for this vital need.

Blue Cross and Blue Shield, the Arkansas Medical Society's voluntary prepaid health plan, needs strong support. Every doctor should recommend the program and do his best to help enrollment in the plan. This is no time for fault finding and disruption. Failure to promote Blue Cross and Blue Shield plan only strengthens argument for group hospital schemes. We need to prove to this state that we are providing the best. We have medical and hospital coverage. Group and

DESOXYCORTICOSTERONE ACETATE AND ASCORBIC ACID IN THE TREATMENT OF RHEUMATOID ARTHRITIS*†

BENJAMIN B. WELLS, M. D., Ph. D., ROBERT D. LOWERY, M. D., and VIRGIL E. SEIBERT, M. D.

Dramatic and immediate relief of symptoms in active rheumatoid arthritis has been observed to follow the administration of desoxycorticosterone acetate and ascorbic acid (1) (2) (3). Since this method of treatment is being actively brought to the attention of physicians, we feel that it is important to record a series of results which have been uniformly disappointing, and in this respect are similar to those reported by Hartfall and Harris (4), Hart and Starer (5), Kellgren (6) and by Spies et al. (7).

Eight patients with active rheumatoid arthritis were treated. In each of these 5 mg. of desoxycorticosterone acetate in oil was injected into the lateral aspect of the gluteous muscle using the precautions mentioned by LeVay and Loxton (2). Five minutes later 1 gram of ascorbic acid was injected intravenously. This combined treatment procedure is that first described by Lewin and Wassen (1). Great care was taken to avoid suggestion therapy. Two of the patients were given a preliminary course of saline injections using the same routine; no effects were noted in these. In one additional patient 25 mg. of testosterone propionate in oil was substituted for the desoxycorticosterone acetate, but the procedure was otherwise identical. The latter course of therapy was suggested by Landsberg (8).

Experimental

Case records and therapeutic results are briefly summarized as follows:

1. A. S., a 46-year-old colored female, had rheumatoid arthritis of eight years' duration involving the shoulders, elbows, hands and wrists, was admitted to our service during an acute exacerbation. There were marked local and systemic signs of activity of the disease. The patient was given four daily treatments with desoxycorticosterone and ascorbic acid as described. There were neither subjective nor objective benefits. Joint involvement increased during the period of treatment.

2. O. B., a 48-year-old white female, was admitted during her first attack of rheumatoid arthritis. The hips, knees and fingers were involved. There were definite signs of activity in the joints and a moderate systemic reaction. The patient was given four treatments. No beneficial effects were noted.

3. D. S., a 59-year-old colored female, had rheumatoid arthritis of nine years' duration. Acute signs and symptoms were referred to the shoulders, hands and wrists. There were systemic signs of active disease. The patient was given three treatments. No effects were noted.

4. H. L., a 39-year-old white male, had rheumatoid arthritis for nine years. Signs of active disease were present in the hips, knees, wrists, shoulders and cervical spine. Five treatments were given at daily intervals. There were no subjective or objective signs of improvement.

5. J. W., a 48-year-old white male, had rheumatoid arthritis of eight years' duration. The chief signs and symptoms at the time of his examination in our clinic were referred to the left knee, right hip and right shoulder. There were systemic signs of active disease. Five treatments were given on successive days. No subjective or objective improvements were noted.

6. F. N., a 48-year-old white female, was seen in our clinic approximately six months after the onset of acute generalized rheumatoid arthritis. Signs of active disease were present in the hands, knees and feet. Five treatments were given on alternate days. There were no evidences of improvement.

7. E. C., a 54-year-old white female had rheumatoid arthritis of three years' duration. She was seen in a recent exacerbation. Active disease was evident in both hands and there was pain and limitation of motion at the right shoulder and elbow. Systemic signs of activity were only moderate. Five daily treatments were given. No subjective or objective improvements were noted.

8. A. B., a 66-year-old white female, had multiple peripheral rheumatoid arthritis of 20 years' duration. There were superimposed signs of degenerative joint disease. This patient was given

*Steroid hormones used in this study were furnished by the Schering Corporation, Bloomfield, N. J.

†From Department of Medicine, University of Arkansas School of Medicine, Little Rock, Arkansas. Received for publication April 25, 1950.

individual enrollment is an early objective. Our plan, which is just a little over a year old, provides coverage for more than 35,000 persons. Its success, so far, has been phenomenal.

There is battle and hard work ahead on every front, and with the awakening of physicians to their responsibilities as citizens and continued cooperation of all counties, we can hope for a brighter future.

only one injection of desoxycorticosterone and ascorbic acid. This, in her opinion, increased the joint pain and produced a feeling of weakness and vertigo.

9. J. C., a 68-year-old white male with rheumatoid arthritis of 25 years' duration involving shoulders, elbows, hands, fingers, neck, hips and knees, was admitted to our service. He was in an acute exacerbation involving particularly the hands and shoulders. There was considerable systemic reaction. This patient was given six daily injections of 25 mg. of testosterone propionate followed by 1 gm. of ascorbic acid intravenously. During the period of treatment the patient noted some improvement in his ability to sleep at night, but there were no objective or subjective improvements in the joint disease.

Discussion

The cases used in this study were carefully examined and observed during a period of several days before treatment was undertaken. In each instance the diagnosis of active rheumatoid arthritis was well supported by clinical, laboratory and X-ray evidence. When desoxycorticosterone and ascorbic acid treatment was given all other therapy was withheld. We were careful to avoid any suggestion of undue confidence in the treatment, and deliberately assumed an unenthusiastic attitude toward its use. All of our results were seen by at least two experienced observers at thirty minutes, two hours and twenty-four hours following the combined injection treatment. None of our patients described the euphoria which has been mentioned in some of the published reports, and we were able to discover no subjective or objective changes to indicate that the patients had received benefit from the treatment.

Our failure to obtain a gratifying response to this therapy is probably no more difficult to explain than are the successes which others have reported. Until the fundamental aspects of this problem are better established, explanations on either side must remain highly speculative. It is our intention to pursue these observations further, making use of steroids other than desoxycorticosterone acetate with subsequent administration of ascorbic acid.

The authors wish to express appreciation to Dr. Walton Van Winkle, Jr., Secretary, Therapeutic Trials Committee, whose counsel and assistance has made these studies possible.

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CORRESPONDENCE

May 6, 1950

Mr. Sid Wrightsman, Jr.
Executive Secretary
Arkansas Medical Society
310 Professional Building
Fort Smith, Arkansas

Dear Sid:

Will you please express to the leaders of the Arkansas Medical Society my sincere appreciation for the thoughtfulness and kindness in doing me the honor of a special Resolution to the Arkansas Medical Association.

I am enjoying my new assignment and I trust that I shall be able to make a contribution that will merit the confidence expressed by the Arkansas Medical Society in this Resolution. My kindest personal regards.

Yours very truly,

Aubrey D. Gates,
Field Director.



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EDITORIAL

OUR PRESIDENT

Earle H. Hunt, installed as the President of the Arkansas Medical Society at the 1950 annual session, was born at Coal Hill, Arkansas, February 16, 1886. He attended the public schools, Hendrix College from 1900 to 1905, Washington University School of Medicine, 1905-1907 and graduated from Tulane University of Louisiana in 1909. His Arkansas license was issued in 1908 and he began practice at Clarksville with his father, the late W. R. Hunt, and the late J. S. Kolb, after one year as resident surgeon at St. Luke's Hospital, Little Rock. He served as the first country health officer in Johnson county and was instrumental, with Drs. Morgan Smith and C. P. Meriwether, in drawing the act establishing the Arkansas State Board of Health. The Johnson County Hospital was organized and operated by Dr. Hunt for 20 years after which time, he assisted in the building of Saint Hildegarde's Hospital at Clarksville, of which he was the first chief of staff and is now emeritus chief of staff. He has attended 42 consecutive annual sessions of the Arkansas Medical Society, and has the unique distinction of having served as councilor for both the eighth and the tenth districts, all the time practicing in Clarksville.

Other medical offices held have been secretary of the Johnson County Medical Society for many years and president of the eighth and of the tenth councilor district medical societies. He is a charter member and past-president of the Clarksville Rotary Club, a member of the Methodist church, a charter member of the Clarksville Gold Club, formerly physician to the College of the Ozarks and actually coached the football team of the college in 7911-12. He is associate professor of gynecology in the University of Arkansas School of Medicine. Married to Miss Ellen Totton Hutcheson at Van Buren in 1912, they have three children and five grandchildren.

A country practitioner who began practice in the horse and buggy days, he has performed over 300 laparotomies in the homes of patients and did one appendectomy in the Boston Mountain country under a cherry tree in 1916, this patient living to have a hysterectomy performed by Dr. Hunt in 1950 in the Clarksville Hospital.

To the affairs of the Arkansas Medical Society at this time, Dr. Hunt brings the full understanding of a physician who has been active in the work of the Society for all the years of his professional life, extending his field of activity from county to state and, recently, being one of the "grass roots doctors" who went to Washington to give the viewpoint of practicing physicians direct to members of Congress on the then pending Reorganization Plan No. 1. Enthusiasm, energy, a sincere and devoted love for the cause of medicine, a tirelessness of spirit in the effort to accomplish the aims and ideals of medicine, are traits possessed by Our President which will be translated into action for a greater and better medical society during 1950-51.

ANNUAL BREAKFAST AT SAN FRANCISCO

The annual breakfast of members attending the American Medical Association sessions will be held in the California Room, Palace Hotel, San Francisco, Thursday, June 29, at 7:30 a. m. Reservations are not required but it will be appreciated if members will notify Mr. Wrightsman, Stewart Hotel, of their intention to attend the breakfast.

RANDOM THOUGHTS OF THE SECRETARY

April 30th. Competition may be essential in private enterprise but a second trip from Kansas City to Fayette-

ville today convinces that there is too much of this spirit on the highways.

May 1st. With an official proclamation from the Statehouse, we have Better Posture Week in Arkansas today, the chiropractor's contribution to better living.

May 3rd. New Zealand, Australia and now comes Florida to demonstrate that "enough is enough."

May 11th. With Pride and Goldstein to Wright's hospital in Waldron where there is interesting material for a diagnostic cancer clinic and where Wright holds forth in clinical session on the recognition, diagnosis and treatment of tularemia, this clinic case taking the edge from Goldstein's granuloma "annie laurie" case who came at his telephonic invitation.

May 14th. Spending our accustomed Sunday in Kansas City, Mother's Day bringing crowds downtown and homeward aboard the Southern Belle, dividing our time between New York Times and the proceedings of the 1950 annual session.

May 15th. With Wrightsman by the airline to Mountain Home where all but three of the active physicians in the ninth district are in attendance at their meeting and thus gratify our desire for more enthusiasm in medical societies . . . homeward piloting an airplane for the first time in several years across the mountains and hills without landmarks to spot Mulberry and the smelter smoke of the home town area with what we are pleased to term excellent navigation and then to land, three-point fashion, all of which contributes to our personal esteem.

May 17th. In numbers from far away places come colleagues to the Johnson County Society banquet honoring President Earle and Vice-president Hardgrave, one of the largest medical gatherings in the state, the annual session excepted, the ladies of the Altar Society purveying their super-excellent fried chicken and angelfood cake and good fellowship and conviviality is at high point throughout the evening.

The Southeast Arkansas Tumor Clinic and the Fourth Councilor District Medical Society met jointly at Pine Bluff May 25th. An open public meeting, addressed by Alton Ochsner, New Orleans, on "Cancer," was held in the morning. Open house was held at the clinic in the afternoon followed by an address, "The Diagnosis of Cancer," Alton Ochsner. A social hour followed by a banquet was addressed by Juan del Regato, Colorado Springs, on "Carcinoma of the Cervix."

BOOK REVIEW

A Textbook of Surgery by American Authors: Edited by Frederick Christopher, B.S., M.D., F.A.C.S., Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Fifth Edition. 1,550 pages with 1,465 illustrations on 742 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $13.00.

The fifth edition of this textbook, with its 198 contributors, all authorities in their fields, offers the medical student a complete ,yet concise coverage of the rapidly expanding field of surgery today.

Dr. Christopher has succeeded in eliminating as much theoretical and controversial material as possible, while including the essentials of etiology, pathology, and diagnosis. The accepted methods of surgical treatment are carefully described and illustrated.

While the entire book is authoritative and up to date, the sections on orthopedic surgery warrant special mention. For in these sections a specialized field of surgery is covered in a general surgery text. These sections should prove of exceptional value to both the student and practitioner.

PROCEEDINGS OF SOCIETIES

Phillips County Medical Society met at Helena on April 27th with the following scientific program: "Newer Concepts of Diagnosis and Treatment of Spontaneous Intracranial Hemorrhage," Francis Murphy and E. C. Schultz, Memphis. President Earle H. Hunt addressed the Society following the scientific program.

The Five-County Medical Society met in dinner session at DeQueen May 18th with Edward Hull, New Orleans, as guest speaker, on "Quinidine in Relation to Heart Disease."

C. N. Jones, Secretary.

The Pulaski County Medical Society was addressed May 11th by Edgar Hull, New Orleans, "The Diagnosis and Treatment of Heart Disease."

At its meeting April 18th in Fort Smith, the Arkansas Radiological Society elected Ed Gray, Little Rock, vice-president, and J. A. Norton, David LeVine and E. A. Mendelsohn, members of the executive committee.

Pope-Yell County Medical Society met in dinner session at Russellville on May 12th with the following scientific program: "Heart Disease," Edgar Hull, New Orleans.

The Ninth Councilor District Medical Society met at Mountain Home May 15th for the following program: "The Diagnosis and Treatment of Heart Disease," Edgar Hull, New Orleans; "Surgical Measures for the Relief of Pain," Robert Watson, Little Rock, and "Convulsive Disorders of Children," E. A. Crawley, Little Rock. The following officers were elected: President, Henry Kirby, Harrison, and secretary-treasurer, William Briet, Harrison. The society will next meet at Harrison.

Carroll County Medical Society has elected the following officers: President, Charles M. Poynor; Vice-president, Ross Van Pelt, and Secretary-treasurer, Fred C. Smith.

PERSONALS AND NEWS ITEMS

In attendance at the American College of Physicians, Boston session, were: L. D. Massey, Osceola; A. A. Blair, Fort Smith, and B. B. Wells and O. C. Melson, Little Rock.

Diagnostic cancer clinics under the sponsorship of the county medical Society and the Arkansas Division, American Cancer Society, were held at Russellville April 28th, by D. W. Goldstein, F. H. Krock and W. R. Brooksher, Fort Smith, and at Bentonville April 27th, by Fred H. Krock, S. W. Hawkins and E. A. Mendelsohn, Fort Smith.

Willis Brown, Eva Dodge, Jessie Cavener, Harlan Hill and Charles R. Henry attended the Fourth International Congress of Obstetrics and Gynecology in New York during May. They also attended the sessions of the Continental Gynecologic Society.

The Blue Mountain Fishing Club has elected Fred H. Krock, president, and W. F. Adams and F. E. Shearer, directors.

J. W. Kennedy has been elected director of the Arkadelphia Rotary Club.

John T. Gray, formerly of Little Rock, has opened offices for the practice of orthopedic and traumatic surgery at 217 East Washington, Jonesboro.

R. B. Robins, Camden, addressed the second annual meeting of the Missouri Academy of General Practice at Springfield on April 27th.

D. W. Goldstein, F. H. Krock, A. S. Koenig, and W. R. Brooksher, Fort Smith, conducted a diagnostic cancer clinic at Fayetteville May 4th under the sponsorship of the Arkansas Division, American Cancer Society, and the Washington County Medical Society.

BORN—On April 28th, a son, Carl Wesley, to Dr. and Mrs. John W. Dorman, Springdale.

S. H. Kirkham has moved from Nashville to 1009 High Street, Little Rock.

Ellis Gardner has been elected vice-president of the Russellville Rotary Club.

BORN—On May 6th, Carolyn, to Dr. and Mrs. L. A. Whittaker, Fort Smith.

WOMAN'S AUXILIARY NEWS



MRS. W. S. RILEY

El Dorado

President, Woman's Auxiliary to the Arkansas Medical Society, 1950-1951

The Woman's Auxiliary to the Arkansas Medical Society held its annual meeting at the Ward Hotel in Fort Smith April 17, 18 and 19. The meeting began with the registration at 10:00 A. M. on April 17. A luncheon for the general membership was held in the Gold Room with Mrs. Louis K. Hundley, president of the Woman's Auxiliary, presiding. Mrs. Charles W. Reid, Pine Bluff, gave the invocation. Mrs. Hundley introduced Mrs. Arthur A. Herold, president-elect of the Woman's Auxiliary to the American Medical Association, Shreveport, Louisiana; Mrs. T. E.

D. W. Goldstein, Fort Smith, attended the Oklahoma Dermatological Society meeting in Tulsa April 30th.

J. A. Norton has moved from El Dorado to Texarkana where he will engage in the practice of radiology at the Texarkana Hospital.

A diagnostic cancer clinic was conducted at Waldron May 12th by D. W. Goldstein, Ben H. Pride and W. R. Brooksher, of Fort Smith.

Rhine, wife of Arkansas' Doctor of the Year; Mrs. R. C. Haynes, president, Woman's Auxiliary to the Southern Medical Association, Marshall, Missouri; Miss Mary McGinn, director of the Women's Division, National Education Campaign of the American Medical Association, Chicago, Illinois. Mrs. Haynes and Miss McGinn gave very inspiring talks.

The general session opened at 2:00 P. M. with Mrs. J. Kenneth Thompson, president of Sebastian County Medical Auxiliary, presiding. The invocation was given by Mrs. Charles W. Dixon, Gould. Introduction was made of our State President, Mrs. Louis K. Hundley. The address of welcome was given by Mrs. A. S. J. Clarke, Fort Smith, to which Mrs. William Hibbitts, Texarkana, gave the response. Dr. Louis K. Hundley, chairman of the Advisory Board of the Woman's Auxiliary, and Dr. Fount Richardson, president, Arkansas Academy of General Practice, spoke. The remainder of the afternoon was devoted to reports from committee chairmen.

The highlight of the day was the "Open Houses," which everyone enjoyed. The party started at 6:30 P. M. at the Cooper Clinic, with the Cooper Clinic doctors as hosts. Hardscrabble Country Club, with the Holt-Krock Clinic as hosts. Dr. and Mrs. A. S. Koenig's home and Dr. and Mrs. Thomas P. Foltz' home.

The Tuesday morning session began with a Past-Presidents' Breakfast in the Silver Lounge, Ward Hotel, with Mrs. W. R. Brooksher of Fort Smith presiding. Mrs. Hundley presided at the general meeting which followed. The invocation was given by Mrs. C. E. Kitchens, DeQueen. The speaker for the morning was the president of the Arkansas Medical Society, Dr. Euclid M. Smith of Hot Springs. The County Auxiliary reports and all other committee reports were read.

The ladies of the Auxiliary joined the doctors for a Memorial Service at the Goldman Hotel with Dr. L. H. McDaniel giving the memorial address.

One of the outstanding features of the Convention was the lovely luncheon given at Hardscrabble Country Club with Mrs. J. Kenneth Thompson, president of the Sebastian County Woman's Auxiliary, presiding. Introduction was made of the past-presidents, state officers, wives of officers of Arkansas Medical Society. Mrs. George B. Fletcher, Hot Springs, Poet-Laureate, delighted the ladies with her poems. Mrs. C. W. Garrison, Little Rock, Historian, gave a history of the Woman's Auxiliary since its organization in 1925. All flowers and decorations carried out the silver anniversary motif. Mrs. W. R. Brooksher was recipient of a beautiful silver tray, honoring her for her splendid work in the state on cancer control as well as Auxiliary work. Mrs. Arthur A. Herold gave a timely talk, after which she conducted the installation of the new officers. Mrs. Hundley presented the gavel to Mrs. Warren S. Riley, El Dorado, incoming president of the Woman's Auxiliary. Tuesday evening at 7:00 the annual buffet supper was held in the Main Dining Room, Goldman Hotel, after which everyone adjourned to the Winter Garden for an evening of dancing.

Mrs. Riley held a meeting Wednesday morning for all new county presidents and state officers. She distributed handbooks which outline the work by months and should prove very beneficial toward a successful coming year.

The Woman's Auxiliary to the Pulaski County Medical Society will have their final meeting of the year on May 17, 1950, at 12:00 noon at the Junior League House, with Mrs. J. Harry Hayes presiding. Hostesses for the day will be: Mrs. Erner Jones, Mrs. J. Nye Compton, Mrs. Peter Thomas, Mrs. John Unruh, Mrs. Frank Kumpuris and Mrs. Elbert Wilkes.

Mrs. Alfred Kahn, Jr.
Publicity Secretary.

Officers who will serve during the coming year were installed at the luncheon meeting of the Union County Medical Auxiliary held Wednesday at noon at the home of the State President, Mrs. Warren Riley. Mrs. Garland Murphy, Jr., was co-hostess for the entertainment.

The new executives are: President, Mrs. Paul G. Henley of Smackover; Vice-President, Mrs. Gardner Landers; Recording Secretary, Mrs. George Burton; Treasurer, Mrs. John C. Newton of Smackover, and Corresponding Secretary, Mrs. J. O. Cooper.

Mrs. Henley announced the appointment of the following committee chairmen: Today's Health, Mrs. Schuler McKinney; Public Relations, Mrs. Garland Murphy, Jr.; Legislation and Study Course, Mrs. Leston Fitch; Doctor's Day, Mrs. Berry Moore; Biography, Mrs. F. G. Thibault; Exhibits, Mrs. P. H. Muse; Program, Mrs. Landers; Publicity, Mrs. Cooper; Extension of Medical Care, Mrs. Newton, and Speakers Bureau, Mrs. Riley, Mrs. Newton, Mrs. Landers, Mrs. L. G. Fincher and Mrs. Henley.

WHEREAS, the increasing trend toward Socialism in this country is a matter of grave concern to all citizens, and

WHEREAS, doctors, as citizens, deplore trends in our national life, which, if continued, would deprive Americans of the heritages and of the principles which have made our great nation, and which have given us the American way of life, and

WHEREAS, the democratic way to restore our American way of living, freedom of initiative and private enterprise rests in the election of officials in state and national government who feel that the American way of living is earnestly to be desired, and that present trends shrould not only be curtailed and curbed, but in many instances should be reversed, Therefore

BE IT RESOLVED by the Arkansas Medical Society in Annual Session assembled at Fort Smith, Arkansas, that as a medical society, we do not endorse any candidate, that we urge each doctor of medicine in the state of Arkansas to assert his right to vote for officials in national and state governments who sincerely support and who desire to perpetuate the standard of living under which America has progressed, and that we call upon every doctor in Arkansas to use his unfailing energy in every possible way to secure the earnest cooperation of all citizens in voting for these officials without respect to personalities or political tenets, but with sole regard to preservation of the American way of living.

PROCEEDINGS, SEVENTY-FOURTH ANNUAL SESSION ARKANSAS MEDICAL SOCIETY

Goldman Hotel, Fort Smith, Arkansas

April 17th, 18th and 19th, 1950

FIRST GENERAL SESSION

Monday, April 17, 1950 — 9:30 A. M.

The meeting was called to order by President Smith.

The invocation was given by Rev. J. W. Hickman, First Presbyterian Church, Fort Smith.

The address of welcome was given by L. A. Whittaker, Jr., President, Sebastian County Medical Society.

The scientific program then followed in order.

"Prolonged Labor," F. E. Whitacre, Memphis, Tennessee.

"Saddleblock and Regional Anesthesia in Obstetrics," H. E. Schmitz, Chicago (Lantern Demonstration).

"Cancer of the Cervix and Corpus Uteri," A. N. Arneson, St. Louis (Lantern Demonstration).

"Conservatism in Gynecology," E. C. Hamblen, Durham, N. C. (Lantern Demonstration).

"Endocrine Therapy in Obstetrics and Gynecology," E. T. Ellison, Texarkana (Lantern Demonstration).

SECOND GENERAL SESSION

Monday, April 17, 1950 — 1:30 P. M.

The meeting was called to order by President Smith.

The scientific program then followed in order.

"Diagnostic Criteria in Arteriosclerotic Heart Disease," B. B. Wells, Little Rock.

"Cardiac Function and Emotional States," Louis F. Bishop, Jr., New York City.

"Heart Catheterization: Its Application to Cardiac Diagnosis with Special Emphasis on Congenital Heart Disease and Mitral Stenosis," Don W. Chapman, Houston (Lantern Demonstration).

"Practical Aspects of Rheumatic Fever," Joseph Rosenzweig, Hot Springs (Lantern Demonstration).

"Use of Anticoagulants in Heart Disease," Charles T. Chamberlain, Fort Smith.

FIRST SESSION, HOUSE OF DELEGATES

April 17, 1950

The meeting was called to order by President Smith at 4:00 P. M.

The Credentials Committee (L. T. Evans, Jack Kennedy) reported that the credentials of the delegates present had been examined, found correct and that a quorum was present.

The Secretary called the roll of the delegates.

The following delegates and county society members seated as delegates by action of the House of Delegates (motion J. O. Rush—Roy I. Millard) were present:

ASHLEY—W. R. Cothern; BENTON—K. A. Siler; BOONE—J. G. Gladden; BRADLEY—W. J. Hunt; CARROLL—J. F. John; CHICOT—H. W. Thomas; CLARK—Jack Kennedy; COLUMBIA—Evan S. Houston; CRAIGHEAD-POINSETT—Joe Verser, J. H. McCurry; CROSS-ST. FRANCIS—J. O. Rush; DESHA—H. T. Smith; FRANKLIN—C. C. Long; GARLAND—Frank Adams, Gaston Hebert; HEMPSTEAD—Jim McKenzie; HOWARD-PIKE—Fred Ferguson; INDEPENDENCE—L. T. Evans; JACKSON—K. K. Kimberlin; JEFFERSON—H. S. Stern; JOHNSON—James M. Kolb; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LITTLE RIVER—N. W. Peacock, Jr.; LOGAN—I. H. Jewell; MADISON—Chas. B. Beeby; MILLER—R. R. Kirkpatrick; MONROE—E. D. McKnight; NEVADA—A. S. Buchanan; PHILLIPS—John B. Terry; POPE-YELL—Roy I. Millard; PRAIRIE—J. C. Gilliam; PULASKI—T. D. Brown, Edwin F. Gray, Charles R. Henry, Edgar J. Easley, Fred Harris, Daniel Autry, Hoyt Allen, Frank Kumpuris, John W. Smith, Robert Jones, George Steinkamp, Elvin Shuffield; SEBASTIAN—Fred H. Krock, T. P. Foltz; SEVIER—C. E. Kitchens; UNION—J. F. Clark, H. J. Mayfield; WASHINGTON—V. O. Lesh; WHITE—S. J. Allbright; WOODRUFF—E. A. McCracken.

Other members of the House of Delegates present were:

President Smith, President-Elect Hunt, Vice-President Charles R. Henry, Councilors L. H. McDaniel, J. J. Monfort, S. A. Drennen, Louis K. Hundley, John H. Wilson, R. C. Dickinson, L. G. Martin, Ellery C. Gay, D. W. Owens and Fount Richardson; Past-Presidents L. T. Evans, P. W. Lutterloh, R. B. Robins, Sam Allbright, H. T. Smith, L. J. Kosminsky, Joe F. Shuffield and M.

L. Norwood; and Secretary W. R. Brooksher.

Fraternal Delegates Earl Woodson from the Oklahoma State Medical Association and Frank Acree from the Mississippi State Medical Association introduced themselves and brought greetings from their respective state societies.

By motion (Drennen-Rush) the minutes of the Seventy-third Annual Session as published in the June, 1949, issue of the Journal of the Arkansas Medical Society were adopted as correct.

President Smith addressed the House of Delegates, expressing gratitude to all members for their cooperation during his term as President.

Committees of the Society then reported in order, each report being referred to the Reference Committee (Fred Krock, Fort Smith, and A. S. Buchanan, Prescott).

COMMITTEE ON ARRANGEMENTS

D. W. GOLDSTEIN, Chairman

Thomas P. Foltz reported for the Committee, giving information on the social functions planned during the session.

SCIENTIFIC EXHIBITS COMMITTEE

ANDERSON NETTLESHIP, Chairman

All members of the Committee have been contacted by telephone and letter. These are: Albert S. J. Clarke, Fort Smith; Raymond Cook, Little Rock; E. L. Dunaway, Conway; and Chas. W. Reid, Pine Bluff.

Dr. Clarke is chairman of the local committee on scientific exhibits. The annual meeting is to be held in the Goldman Hotel, Fort Smith; and it has been determined that the scientific exhibits will be on the mezzanine floor. The mezzanine floor will accommodate seven booths approximately 12x8 sq. ft. and three smaller booths, so that a total of ten spaces will be available.

Letters have been sent to people who exhibited in last year's scientific exhibition, as well as other doctors and groups throughout the state. Since last year's scientific exhibits were so successful, it is hoped that the exhibits this year will be equally worthwhile. The Committee has made sincere efforts to contact anyone who may wish to contribute to the exhibition, and it is to be hoped that all parties will consider this as a further invitation to give a scientific exhibit.

Addressing the House of Delegates, Chairman Nettleship stated that his Committee desired to add two recommendations not included in its published report: (1) That an annual award be given to the best scientific exhibit at future Annual Sessions of the Society, and (2) That adequate financial support of the scientific exhibits be given by the Society each year.

REPORT OF SCIENTIFIC PROGRAM COMMITTEE

H. KING WADE, JR., Chairman

At the suggestion of Doctor Euclid Smith, President of the Arkansas Medical Society, and with the wholehearted approval of the entire Committee, an attempt was made to arrange a program which would be of the greatest value and the most practical use for the general practitioner in the State of Arkansas.

I would like to extend my sincere thanks at this time to all the members of this Committee for their hard work on behalf of this program, and for their one hundred per cent attendance at each monthly meeting of the Committee. Their co-operation was one hundred per cent, and it was a real pleasure to work with this group.

I also wish to thank Doctor Charles R. Henry for taking the responsibility for, and successfully arranging, the GYN-OB Symposium. I wish to thank Doctor Driver Rowland, of Hot Springs, and the members of the Arkansas Heart Society for their co-operation in the preparation of the Cardio-Vascular Symposium.

I wish to thank all the members of the State Society who were interested enough to submit papers. I deeply regret that we were unable to accept every application.

As a Committee, we have one recommendation to make for future programs; we suggest and recommend that the House of Delegates appropriate a given fund and that this fund be turned over to the Chairman of the Program Committee each year for use in obtaining out-of-state speakers.

COMMITTEE ON NECROLOGY

L. H. McDANIEL, Chairman

Chairman McDaniel announced that the annual Memorial Service to be held April 18th would constitute the Committee report and urged all Society and Auxiliary members to attend.

PRESS COMMITTEE

L. A. WHITTAKER, Chairman

As Chairman of the Press Committee for the Annual Session of this Society to be held in Fort Smith in April, I have contacted Mr. C. F. Byrns, editor of the two Fort Smith newspapers. Mr. Byrns has assured the Society full co-operation of both papers on press coverage during the Session.

MEDICAL LEGISLATION COMMITTEE

JOE F. SHUFFIELD, Chairman

Your Legislative Committee has collected material from other states concerning a "Modern Medical Practice Act" for Arkansas. Your legal staff and the Committee have studied this material. Due to the fight on socialization of medicine we have felt it would be wise to wait until the Legislature of 1953 to introduce this because a fight might develop that would interfere to some extent with our efforts against the national problem. We wish to continue to study this material and bring to the House of Delegates of 1952, a completed modern medical practice act. However, if this House wishes us to introduce such an Act in the Legislature of 1951 we will finish it and be ready before the Legislature convenes in January, 1951.

This being an "off" year for the Legislature, we have had no real work to do.

We wish to remind every physician of our Society that this is election year and that they should see to it that their county elects the best man who is running for office and be sure that he has the proper attitude towards our problems, and towards socialization in general. Also, see that the man that is elected knows that the Legislative Committee represents YOU. Tell him that he can depend on the Committee. He will believe in you and will believe in the Committee, if you tell him so.

We wish to relate to this House that there is a representative of the Pure Food and Drug Administration living in Little Rock and his actions are state-wide. He is telling the druggist that under strict interpolation of the regulation of his department that they cannot refill any prescription without the approval of the doctor who wrote it, but at present the department was only checking the

most important drugs. The druggist thinks this is only an entering wedge and soon the Food and Drug Administration will prevent the druggist from refilling any prescriptions. The druggist believes this is being done to force the people to go back to the doctor and run up the cost to the sick and to cause the people to become displeased with the present practice of medicine, thereby causing the people to clamor for state medicine. The druggist thinks this may be an act of the Social Security agency through the Food and Drug Administration. The National Association of Retail Druggists have had Congressman Carl T. Durham of North Carolina to introduce H. B. No. 4203 to combat this activity by the Food and Drug Administration.

Your Committee is keeping up with this and with the activities in Congress concerning the socialization of medicine. We appreciate and approve of the good work that is being done by Dr. Charles Henry and his Committee.

LEGAL AFFAIRS COMMITTEE

J. B. JAMESON, Chairman

Your Committee wishes to make its first annual report. After considerable study and thought we have reached certain conclusions as to the function, policies and recommendations herein submitted.

First, this Committee is to act as a liaison and recommending group between the Arkansas Medical Society and the Arkansas State Board of Medical Examiners and, secondly, to act as the agency of the Arkansas Medical Society in medico-legal affairs.

(1) We find that the Arkansas Medical Society has available, competent legal talent capable of handling any question of a legal nature which might arise. In this we concur and recommend that this or a similar service should continue to be available.

(2) We find that the affairs of the Arkansas State Board of Medical Examiners have been conducted in a commendable way. Their financial condition is good and they are operating within their income, but with a margin not excessive of their needs. A detailed financial report will be made through the proper channels at a future date. They have excellent legal talent capable of handling any situation which might arise. They also have at their command means of prompt and efficient investigations of any infraction of the medical practice act. We wish to commend them for their untiring efforts and in the work they are doing. We therefore wish to recommend to the Arkansas Medical Society, its official bodies and individual members, that:

(1) In the future when anything arises which pertains to the existing policy of the State Board of Examiners, conduct of affairs, or expenditures, it first be submitted to this Committee through its chairman at that time, for proper investigation and recommendations. By expenditures we mean the transfer of funds to other agencies, and not funds used by them in the conduct of their business. It being understood that such recommendations made by this Committee will be referred to House of Delegates for approval or disapproval.

(2) That any known violation of the Medical Practice Act, first be reported to the chairman of this Committee, in writing, with as much evidence as possible. It is to be desired, if possible, that such notice or request for investigation come from the county society involved or from the nearest society, if the county involved is not organized.

(3) We recommend that at present no change be made in the annual registration fee.

(4) We recommend that in the near future the state society, through its Legislative Committee, cooperating with the State Board of Examiners, begin to think about either rewriting or bringing up to date the existing Medical Practice Act.

We also recommend that the State Board of Examiners in a like manner use the offices of the Legal Affairs Committee in any way they see fit, to bring before the State Society, any question requiring official action.

It is our hope that in adopting these recommendations a closer and more harmonious situation can be effected between the State Society and the Board of Examiners.

MEDICAL SERVICE COMMITTEE

J. A. HENRY, Chairman

The following is a report of the Medical Service Committee of which Dr. J. A. Henry, Russellville, is chairman; composed of the following men: Dr. Norman Peacock, Ashdown; Dr. J. F. Jackson, Newport; Dr. Dickins, Pine Bluff; and Dr. John Sneed, Conway (not participating).

The report of the Committee's work, and the recommendations resulting from this work, are as follows:

Recommendation 1. We recommend that the State Medical Society endorse, and initiate legislation, setting up a medical scholarship loan program for the State of Arkansas.

The purpose of this scholarship program is to fulfill the need of family physicians in the rural areas of Arkansas. Approximately seventy-five per cent of the physicians practicing in the rural areas are now sixty years of age or older; and it is our belief that the majority of these physicians will not be replaced after they pass on. The shortage of physicians in the rural areas threatens the welfare of a large number of the citizens of Arkansas.

Socialized Medicine proposes that doctors will be sent into these rural areas where there is a real need. It behooves the State Medical Society to do what they can to rectify this need of doctors in the rural communities. By doing so, we will be attempting to solve the problem, and to let the public know that we are interested in their needs. We feel that this will be striking a real blow against the threat of Socialized Medicine in the State of Arkansas.

At present there are nine states which have scholarship loan programs; with the idea in view of the students returning to the rural sections and practicing a certain length of time, in order to pay back the loan which enabled them to attend school. Mississippi has the most ambitious and probably, so far, the most successful plan, to aid students to obtain a medical education, and to return to rural practice. The proposed plan of ours is modeled partially after the Mississippi plan.

Our recommendations toward setting up such a program are as follows:

A. The source of funds we believe should come through the State Legislature. We feel that a program of this sort would be a great aid to the state, and that it should be financed by the state. We believe that no federal funds should be used in this program, because we fear that the use of federal funds would take the program out of the hands of the state, and the State Medical Society, and that we would be playing into the hands of Socialized Medicine.

B. The maximum total loan, per student, we proposed to be four thousand dollars. The maximum amount of the loan available per year, per student, would be one thousand dollars.

C. The loan will be available to any bona fide resident of the State of Arkansas who has finished his pre-medical requirements, and who can prove that he is unable to finance his medical education without the aid which we propose to offer. We think this student should be a resident of the state for at least eight years in order to be

eligible for assistance. We believe that a limited number of the scholarships should be offered to colored students in order that certain rural areas composed chiefly of colored people could have better medical assistance.

D. We think the student should be allowed to attend any approved, class A Medical School in the United States.

E. After having finished his medical education, we think the student should be required to serve one year rotating internship; with an option to take two years of rotating internship. We do not think he should be permitted to take more than two years of hospital work before fulfilling his obligation to return to rural practice.

F. The method of credit: We think that the student should be credited one thousand dollars for each year that he spends in rural practice.

G. We think the size of the community should be one of twenty-five hundred population or less, according to the census of 1950.

H. We think that he should be given complete credit for his loan after having finished four years of practice in a rural community. We recommend that he spend a minimum of two years of such practice, regardless of the amount of money which he has received.

I. We think that these students should be selected by a board whose chairman is the President of the State Medical Society, and a group of four or five other doctors, who will serve three to four-year terms. We think there should be no set time for the duration of this program.

J. We feel that a student who receives this aid should be under a moral obligation to serve his time in rural practice. However, we think that to forestall any possibility of the student not doing so that he receive a temporary license to practice in the State of Arkansas. This license would be revoked in the event he failed to fulfill his part of the contract.

K. We feel that after the doctor has spent the minimum of two years in rural practice, and in event that he wants to leave, that he be allowed to do so, after paying his remaining indebtedness plus two per cent interest.

L. We do not feel that any definite limit should be set on the number of students. However, we think that four or five students in each class, that is, a total of sixteen to twenty students, would be a fair beginning. A program of this kind would not be too expensive, and we feel that if it were endorsed by the State Medical Society, and with the proper publicity, that it could be put through the State Legislature without too much difficulty.

M. We feel that it would be doing something concrete to aid the rural sections in obtaining good doctors. We think that we would be doing a great service to worthy and needy students who might not be able to go through medical school without such assistance. We also feel that such a program might induce these men, once in rural practice, to form groups, and then to form small hospitals, which would be one of the main answers to the need of a better type of medical practice in the rural sections.

Recommendation 2. We suggest that the University of Arkansas School of Medicine require each senior student to serve a two weeks preceptorship with a general practitioner. We think that preferably this practitioner should be located in a small community or in a rural area. We think that this would do much to educate the student, and to create interest in general practice.

Recommendation 3. We recommend that the State Medical Society each year sponsor a dinner at one of the hotels in Little Rock, to which would be invited all the residents, and assistant residents, in the approved hospitals in Arkansas.

We suggest that this be a forum at which time these residents could ask questions of a representative group of doctors in rural practice. In this way, the residents could gain a better idea and possible interest in general practice in small communities.

Also that the State Medical Society, at that time, have a list available of the communities which need and desire a doctor.

Recommendation 4. We suggest also that the University of Arkansas School of Medicine, through the University Hospital, endeavor to create a two-year rotating internship which is primarily for men who wish to go into general practice.

Recommendation 5. The Committee was directed to meet with and to discuss with Dr. Joe T. Shuffield, the various agencies engaged in helping the crippled of Arkansas. This was done January 29, 1950, and it was found that no serious difficulties or conflicts existed.

A letter was sent to the heads of the various agencies, advising them of the existence of a Medical Service Committee of the State Medical Society, and of our desire to be of any possible assistance.

Chairman Henry stated that his Committee presented the following amendment to the published report:

When the Medical Service Committee considered proposed legislation for financing needy medical students, it was understood that similar legislation had been proposed, but had failed to pass the Legislature.

Correspondence with Mr. P. A. Deisch and with the Attorney General's Office reveals that there was an Act No. 131 passed by the last Legislature, which offered financial aid to the needy medical students, but the appropriation has never been obtained to carry out the program.

We recommend that if the Council thinks that the State Society should endorse legislation for this purpose, that the present Act No. 131 be amended, and that attempt be made to obtain funds to make the program active.

We submit a copy of Act No. 131 which can be compared with the Committee's previous recommendations.

MILITARY MEDICINE COMMITTEE

EWING M. NIXON, Chairman

The following is submitted as a report of the Military Medicine Committee of the Committee of Medical Service of the Arkansas Medical Society.

In November, the chairman of this sub-committee met with the other chairmen of the medical service section at the Albert Pike Hotel, Little Rock. This meeting was of distinct interest to the writer in that the functions of the Military Medicine Committee and other committees were discussed.

On December 8, 1949, the chairman of this sub-committee appeared in a panel discussion in the Robinson Auditorium, Little Rock, Arkansas, for a discussion of Governor McMath's disaster relief program. Mr. Herman E. Lindsey, Chief of the Arkansas State Police, acted as chairman of the panel discussion, and the following speakers were heard: Mr. Herman E. Lindsey, Chief, Arkansas State Police; Brig. Gen. H. L. McAllister, Commanding General, Arkansas National Guard; Mrs. Elma B. Boone, State Relations Officer, American Red Cross; Capt. Frank McGibbony, Public Relations Officer, Arkansas State Police; Mr. Jack Warren, Superintendent, Davis Hospital, Pine Bluff; Ewing M. Nixon, Chairman, Military Medicine Committee, Arkansas Medical Society.

From this discussion it is evident that considerable progress has been made towards the establishment of a definite program to combat disasters in the State of Arkansas, and it is paramount that complete cooperation be present in such a disaster. The function of each agency of the Arkansas State Police, the American Red Cross, the Arkansas

National Guard, Arkansas State Highway Department, the Arkansas State Board of Health, and the Arkansas Medical Society were carefully discussed. The fullest cooperation from the Society, the County Society, and the individual doctors was assured to the other agencies by the writer.

As an example of the need of further study, planning, and teamwork, the overlapping of aid attempts, and lack of facilities during the tornado at Warren, Arkansas, in January, 1949, was a prominent part of the discussion. It was evident in this discussion that there was considerable duplication of effort, and waste of supplies and personnel during this emergency.

Many of the speakers at the panel discussion complimented the doctors of the State of Arkansas for their willingness to help in the Warren tornado as evidenced by their presence at the site immediately following the disaster. It is hoped that further concerted effort can be had to develop a well-rounded disaster relief program.

VETERANS ADMINISTRATION COMMITTEE

DANIEL H. AUTRY, Chairman

Because of reduced budget expenditures and because of increased medical personnel on the staff at the regional office of the Veterans Administration at Little Rock, the total number of fee basis examinations and treatments throughout the state was slightly below the preceding year. Apparently the physicians have become well informed regarding the completion of necessary written forms, as the administrative officers of the V.A. report a minimum of difficulties in this regard.

There has been a misunderstanding on the part of many veterans when they were instructed to get a complete examination by their local physician to be sent to the V.A. Rating Board, since such veterans usually felt that the V.A. would be responsible for the cost of such examination. This situation has led to embarrassment on the part of both the veteran and the local physician. Representatives of the V.A. have stated that in the future all letters requesting the veteran to secure such examination will include the information that the veteran must pay the physician his usual charges for same.

Many physicians wonder why they do not receive written hospital summary reports on patients whom they have referred to a V.A. or other Government Hospital. Such reports can be sent only upon written authorization of the patient. It is urged, therefore, that all physicians desiring reports of hospital findings, request that the patient, before leaving the hospital, give written authority for the hospital officials to mail such reports back to the referring physician.

INDUSTRIAL HEALTH COMMITTEE

SAMUEL B. THOMPSON, Chairman

The Committee on Industrial Health met in the Donaghey Building, Little Rock, Arkansas, at 2:00 P. M., Sunday, January 29, 1950, with Dr. H. K. Wright of Hot Springs, Dr. Ellis Gardner of Russellville, and Chairman in attendance.

The Committee voted to send Dr. L. D. Massey of Osceola a letter of sympathy, in regard to the recent accident which prevented his attending this meeting.

The standard form for the initial surgeon's report of compensable injuries was examined, with regard to Items 9, 10 and 11. It is the recommendation of this Committee that if the physician in charge should feel that a patient's confidence might be violated in answering these questions, that he should secure an authorization from the patient, before submitting such information.

It is felt that the individual physician should use his own judgment about the running of accessory tests or procedures in determining the patient's general health, following an accident, and seek authorization from the insurance company only where unusual procedures are involved.

The Committee takes cognizance of the fact that there is a statute in the State of Arkansas requiring the reporting of occupational diseases. This has not been very rigidly enforced and it is recommended, to the Society, that the profession cooperate in reporting these diseases.

The Committee recommends that industrial plants operating a health program, including nursing, first aid, etc., set up such a program under the supervision of a medical director, who should be a licensed M. D., who would be responsible for the action of the nurses and first aid men; would familiarize himself with the job requirements and working conditions of the plant, by periodic visits to the plant; and would act in an advisory capacity to the management on elimination of occupational hazards and the provision of first aid to the employees.

The Committee takes cognizance of the existence of the Grievance Committee, established by one of the county medical societies to further better relations between the insurance adjusters and doctors doing industrial work. The function of this committee should be watched with great interest by the Society, in regard to what this type of program has to offer in the way of improving relations between industry and the medical profession.

The Committee recommends that any long-range plans for setting up rehabilitation centers for industrial casualties, that might be advanced by industry or insurance carriers, be encouraged by the State Medical Society.

MENTAL HYGIENE COMMITTEE

GEORGE W. JACKSON, Chairman

The report of last year emphasized the magnitude of the mental health problem in our state by quoting statistics on the incidence of mental illness, as well as comparative figures on general hospital and mental hospital beds. This report will cover only specific phases of the mental health program: The aged, the mentally deficient, sex crimes and sex offenders, personnel training, and progress report of the State Hospital.

The care and treatment of the aged or geriatric type patient is becoming an ever-increasing problem. The advances that have been made in medicine in recent years have increased the life span of the average person and it can be expected that more and more individuals will show mental manifestations in the form of loss of memory, confusion, and disorientation, making them a greater problem of management within the home and many becoming wards of the state. At the time of this writing there are approximately 1,100 such cases confined in our mental institutions. A high percentage of this group could be adequately cared for in some type of home for the aged.

A survey was completed last year by the Council on Children and Youth to determine the approximate number of mentally deficient individuals of school age within our state. This survey revealed that there are approximately 5,000 children within the state who are unable to profit by attendance in the regular public school system, but who would benefit by special classroom instruction. Approximately 4,500 of those individuals could be adequately trained by special classes within our regular public school system. The remaining 500 would require care and training in an institution for the mentally deficient. The Committee on Mental Hygiene last year recommended that steps be taken to construct a building for those cases requiring institutional care near one of our Teachers' Training Institutions and that special courses of instruction be provided in the college to train teachers in the teaching of the mentally handicapped child not only to supply the needs of

the institution, but to supply the state-wide needs in carrying out the training program of the regular public school system.

The public's attention has been focused in recent months on the increase in the number of sex crimes and sexual offenders. This Committee is aware of this problem and is most anxious to render any assistance possible in working out the necessary legislation to protect society against these offenders and also to assist in the proper confinement and rehabilitation where possible of the offender. Representatives of the Mental Hygiene Committee met with the newly organized State Crime Commission, entered into a discussion of the problems involved and offered the assistance of this Committee as well as the State Medical Society, in working out a satisfactory solution of this problem.

The development of an adequate mental hygiene program in our state is dependent upon the training of the necessary personnel to carry out such a program, as well as the providing of the necessary physical plants and facilities for adequate treatment of the mentally ill. The State Hospital is our largest mental hospital within the state and, although badly overcrowded, is attempting to improve the treatment received by the patients admitted, as well as to institute training programs which in time will provide the necessary personnel for the state-wide needs. In order that the Medical Society may be acquainted with the progress that is being made in the State Hospital, a complete report of the operation of this unit for the year 1949, together with a statement of the proposed improvements and progressive changes to be made during 1950, is incorporated in this report.

IMPROVEMENTS AND PROGRESSIVE CHANGES MADE AT THE ARKANSAS STATE HOSPITAL DURING YEAR 1949

HOSPITAL OPERATION

1. At the request of the superintendent, a comprehensive and thorough survey of all hospital units was made by the Department of Hospitals of the State Health Department. All discrepancies in hospital operation and maintenance were noted and corrective action was initiated.

2. Hospital administrative and operational procedures were revised and modernized in order to meet the basic standards of the American Medical Association, the American Hospital Association, and the American College of Surgeons. Approval of the former agencies has been procured and the third approval is anticipated.

3. Changed visiting hours from 8:00 A. M. to 4:00 P. M. to 1:00 P. M. to 4:00 P. M. in order to allow professional personnel more time to work with patients.

4. Developed and placed in operation a modern up-to-date system of reporting and following up on employee accidents (also accidents involving state vehicles).

5. Developed a system of fire calls for all hospital buildings at the Little Rock Unit in order to expedite the movement of patients in case of fire.

6. Established a position of "Safety Engineer" and began a safety program to eliminate accidents within the hospital. Job was assigned as additional duty to fire marshal.

7. Established a personnel health unit with a full-time physician in attendance. This duty was assigned as an additional duty to the physician in charge of the infirmary.

8. Established and furnished, with the aid of the Volunteer Workers at this hospital, two new recreational dayrooms and a patients' recreational center.

9. Established an employee dayroom for employees coming on and off duty and those living on the station, so that they have a place to go when off duty other than lounging in the halls of the buildings.

10. Established a six months probationary period for all employees.

11. Placed in operation a comprehensive efficiency rating program calling for quarterly ratings the first six months and yearly thereafter on all employees. (Note: Doctor and nurse program has not yet been placed in operation.)

12. Concentrated the patient's admission section of the hospital into one area so that patients can be admitted more efficiently with a smaller outlay of professional time.

13. Placed in operation a system of numbered hospital memorandums and bulletins in order to insure that all personnel are familiar with operational rules and regulations.

NURSING SERVICE

1. A new selection procedure was established for all new attendants with emphasis placed on intelligence and personality stability testing.

2. A three-year training course was established for selected attendants to train them to become psychiatric technicians. This school consisted of 780 hours of didactic lecture (200 hours of dynamic psychiatry) and 6,700 hours of supervised and graded on-the-job training.

3. Standardized all attendant uniforms throughout the hospital.

4. Initiated and carried out local psychiatric aide of the year program and entered the winning aide from the Little Rock and Benton Unit in the National Psychiatric Aide of the Year Contest.

PROFESSIONAL SERVICE

1. Revised and modernized all psychiatric treatment techniques.

2. Revised and simplified much of the professional administrative work, thereby eliminating excessive paper work and improving care and treatment of patients at less cost.

3. Initiated project to modernize pharmacy and simplify handling of drugs in hospital.

4. Started campaign to eliminate virtually all forms of mechanical restraint and seclusion. Developed new and revised rules for application and reporting of restraint and seclusion.

5. Developed and placed in operation new professional charting procedures. Developed new forms and placed working chart on each patient on the patient's ward. The latter change allows physician to have all the information about a patient without having to leave job and go to record room.

6. Initiated and placed into effect new rules for handling criminal observation cases and the criminally insane.

7. Established a Department of Medical Rehabilitation composed of the following sections: Occupational Therapy, Manual Arts Therapy,* Educational Therapy,* Community Retraining,* Recreational Therapy, Athletic Therapy.*

8. Initiated system of assigning patients to hospital details for therapeutic reasons rather than for sheer purpose of working patients to keep hospital operating.

9. Established a council of Volunteer Workers under the direct supervision of the Chief of Medical Rehabilitation and started a compulsory 14-hour training program for all Volunteer Workers.

10. Set up and placed in operation a modern acute intensive therapy ward for women and one for men.

11. Developed and placed in operation a new procedure for reporting accidents to and assault upon patients. Appointed a special investigating officer to check into any

*Sections have not been completely activated.

questionable accidents and a board to investigate any severe injuries or questionable cases of mistreatment.

12. Had a comprehensive survey of dietetic system at all units made, and began to take action necessary to correct discrepancies in operation.

13. Consolidated some of the hospital dining rooms in order to improve service to patients and decrease operational costs.

14. Installed cafeteria system in all dining rooms. This system allows patients all they want to eat but cuts down on food waste. Also allows the patients to be fed more rapidly.

15. Consolidated all vegetable preparation from individual wards into central preparation room with a resultant saving in time and foodstuffs.

16. Standardized all menus so that patients and personnel receive the same food. This has decreased food cost and has improved character of food.

RESEARCH AND EDUCATION

1. Established and placed in operation a full-time department of Research and Education under the direction of a full-time physician.

2. Established a 3-year training course for attendants (see Nursing Service).

3. Established in conjunction with the local Veterans Administration Hospital a one-week training course in psychiatry for student nurses in Arkansas.

4. Made an analytical study of present and future patient loads, especially as effected by older aged patients.

5. Established a professional journal club for doctors and nurses to assist in keeping them current with development in the field of psychiatry.

6. Organized and developed a medical library for the hospital and assigned a secretary to act as librarian as an additional duty. Also worked out a reciprocal exchange with the V.A. and University of Arkansas libraries.

7. Organized and placed in operation ten major research projects.

8. Developed a curriculum for a resident training program and procured teachers for the program.

9. Worked out details for psychoanalytical training of resident physicians undergoing residency training at this hospital.

10. Worked out details of procuring professional teaching equipment and supplies on an exchange basis with the University Medical School, State Health Department and the Veterans Administration Hospital.

11. Made arrangements with the State Department of Education for their assistance in setting up training courses in work simplification and dietetic employee indoctrination.

ADMINISTRATIVE

1. Moved collection section of finance next to admission office in order that finance department may contact relatives before patients are admitted.

2. Identified and officially marked all hospital supplies and equipment.

3. Placed in operation a modern system of charging out property to responsible individuals.

4. Set up a perpetual inventory system on all non-expendable equipment and supplies.

5. Developed and placed in operation a modern system for requisitioning, processing, accounting for, and charging out supplies.

6. Concentrated all business offices (including personnel) in the administration building in order to improve efficiency and cut cost.

7. Developed and placed in operation new finance, supply and raw food cost control program based on I.B.M. accounting system. This improved efficiency and effectiveness of operation and cuts operational costs.

8. Established and placed in operation a modern intra-hospital linen exchange with a resultant decrease in loss of linens while making more linens available to patients.

9. Establishment of a more modern laundry department which allows hospital to launder ALL patients' clothing.

CONSTRUCTION

1. Buildings completed: A. Little Rock—Laundry, cold storage, greenhouse, Manual Arts building—male, Manual Arts building—female, Occupational Therapy and Classroom building, salvage building, 3 garages for doctor's cottages. B. Benton—Addition to laundry, carpenter shop, T. B. building addition, 4 doctor's cottages, new incinerator building, Farm Recreational building, garbage disposal and can washing building. C. Baucum—Patient Recreation building, machine shop building, vegetable pre-cleaning and packing shed.

2. Buildings under construction: A. Little Rock—128-bed N.P.-T.B. building. B. Benton—400-bed ward building, meat curing, cold storage and cannery building.

MODERNIZATION AND REFURNISHING

1. Removed all wood tables and benches from dining rooms and replaced them with modern, plastic-covered, stainless steel tables and chairs.

2. Substituted plastic dishes and modern stainless steel cafeteria trays for outmoded ceramic dishes and formerly used food pans (latter pans were used as dishes by patients and were made in the tin shop, often of galvanized iron).

3. Installed eight showers in male colored ward where there was only one bathtub for 300 patients; also installed four urinals, one in each latrine, so patients could discontinue urinating in drains in middle of latrine floor.

4. Remodeled certain of bathrooms on female patient wards and added showers so that there would be at least two bathing facilities for each 175 patients instead of the usual one bathtub.

5. Constructed three modern hydrotherapy rooms on acute intensive treatment wards so that tub baths and packs could be given in accordance with the dictates of modern therapeutic practices.

6. Installed a number of ward treatment and drug rooms and furnished same with basic therapeutic equipment.

7. Installed 12 circular fire escapes on nine ward buildings in order to facilitate the removal of patients from buildings in case of fire.

8. Painted and redecorated six wards (hallways, rooms, alcoves and nurses' offices).

9. Completely repainted outside of all farm buildings (barns, slaughterhouses, etc.) at Benton Unit and painted all trim on eight ward buildings. Painted exterior of all wooden buildings at Little Rock.

10. Repaired roofs on all hospital buildings at Benton and two major buildings at Little Rock.

11. Remodeled and modernized interior and equipment of slaughterhouse at Benton so that it now meets with the approval of the State Health Department.

12. Installed new and repaired certain old equipment in the milk processing building at the Benton Unit so that pasteurizing and homogenizing plant now meets State and National Health standards.

13. Repaired and repainted administrative area in central building at Little Rock.

14. Repaired, refloored and repainted bakery at Little Rock.

15. Repainted and repaired 100 hospital beds as a vocational retraining project for patients and bought 400 new beds for the various wards of the hospital.

16. Purchased and placed in operation new plastic-

covered, stainless steel furniture for certain hospital wards and dayrooms.

17. Remodeled, re-equipped and modernized the hospital morgue and post-mortem rooms.

18. Installed cold water fountains to replace water barrels and community drinking cups.

IMPROVEMENT TO GROUNDS AND ROADWAYS

1. Began a vocational training program for patients in grounds maintenance and started project of leveling lawns, planting grass and relandscaping areas at Little Rock and Benton.

2. Repaired all hospital streets at Little Rock and Benton and added one mile of new oiled roadway at Little Rock, also repaired sidewalks at Little Rock Unit.

3. Constructed four special parking areas at Little Rock Unit and eliminated "on the lawn" parking and placed road blocks to eliminate destruction of hospital lawns.

4. Invested in and placed in operation new mechanical mowing machines at Little Rock and Benton in order to improve lawn care and maintenance.

FARM IMPROVEMENTS

1. Eliminated from dairy herd 125 head of cattle that were suffering from chronic mastitis and had remainder of herd checked and treated. This action eliminated the use of contaminated milk by hospital. Bought milk cows and replaced 52 of the eliminated herd.

2. Initiated a program of pasture improvement and soil control at Benton and Baucum. Baucum pastures were second in Pulaski County Pasture Contest.

3. Initiated and brought to virtual completion a program of drainage for the Baucum Farm with the result of improving quantity and quality of land. Drainage was done by leveling and establishment of permanent drainage ditch system.

4. Repaired, replaced, and relined virtually all fences at Baucum and installed new field fences at Baucum and Benton farms.

5. Repaired and overhauled eight farm tractors (Benton and Baucum) and various other pieces of farm machinery.

6. Purchased and placed in use: a new combine, hay baler, manure spreader and fertilizer distributor; replaced oat drills, hayrakes, disk harrow, mowing machines, etc.

7. Began a progressive program of land reclamation at Benton consisting of timber clearing, installation of permanent pastures on erodible soil, along with installation of terracing and draining.

ADMISSIONS, RE-ADMISSIONS, DISCHARGES, AND DEATHS

For the Calendar Years 1945 through 1949

	1945		1946		1947	
	M	F	M	F	M	F
First admissions	929	662	1,061	627	881	635
Re-admissions	202	168	202	137	304	230
Total	1,131	830	1,263	764	1,185	865

	1948		1949	
	M	F	M	F
First admissions	906	647	949	633
Re-admissions	211	192	253	211
Total	1,117	839	1,202	844

	1945		1946		1947	
	M	F	M	F	M	F
Discharges, Direct	151	58	233	36	218	36
Discharges, on C.D. or Escape	474	419	639	431	721	544
Deaths	359	242	294	200	399	271
Total	984	719	1,166	667	1,338	851

	1948		1949	
	M	F	M	F
Discharges, Direct	207	39	202	37
Discharges, on C.D. or Escape	596	530	625	626
Deaths	243	170	249	146
Total	1,046	739	1,076	809

PROPOSED IMPROVEMENTS AND PROGRESSIVE CHANGES TO BE MADE AT THE ARKANSAS STATE HOSPITAL DURING YEAR 1950

HOSPITAL OPERATION

1. All reorganization and modernization programs begun in 1949 will be carried on toward completion during 1950. (See Improvements and Progressive Changes made at Arkansas State Hospital during 1949).

2. A new table of organization will be drawn up setting up divisions, services, sections and units. All divisions will be reorganized, modernized and streamlined. This should result in a more efficient and effective organization at less overall cost to the taxpayer.

3. The hospital will establish an annual intra hospital budget system based on quarterly operational activity.

4. Standard job requirements will be developed for all hospital positions and position descriptions will be written on all jobs.

5. A fire department will be established at the Benton Unit. The proper trucks will be procured, if possible, from surplus. Personnel to man the unit will be established on a volunteer basis.

6. Fire rules will be established for all wards and buildings on an individual unit basis. Rules will state what is to be done by personnel, where patients are to go, etc.

7. Standard, regular, fire drills will be held monthly on all buildings at both units.

8. A program of weekly hospital inspection will be inaugurated during 1950. Under this program, six teams composed of one doctor and one administrative chief will inspect one of six hospital districts. As teams will rotate each week, each team will have been through the entire hospital every six weeks. Deficiency reports will be turned in to superintendent.

PROFESSIONAL SERVICE

1. All progressive changes started during 1949 will be continued into 1950. Many of the new, modern programs should be completely in operation on or before the middle of the year.

2. Emphasis will be given toward enlarging and improving the Medical Rehabilitation Division at this hospital. Special emphasis will be placed on development of Community Retraining and Vocational courses in such subjects as: agriculture, horticulture, masonry, upholstering, cabinet making, sewing, etc. Every effort will be made to coordinate these training activities with the maintenance of the hospital and its equipment.

3. Additional treatment techniques will be instituted during 1950. Special emphasis being placed on group type therapies.

4. All professional administrative procedures will be brought up to the latest and most efficient standards. This will be true especially of patient records, processing, etc.

5. Admission and staffing procedures will be modernized and streamlined and present treatment center will be decentralized. This will allow patients to start their psychiatric treatment within 24 hours after entering the hospital. (At present, although the time lay before initiation of treatment has been cut from months and weeks to a number of days, better results could be obtained by more rapid institution of treatment.)

6. The dietetic department will centralize most of its kitchens and will substitute the movement of food to the various dining rooms by electrically heated food carts. This will allow for more cooks in main kitchen with more economically and better prepared food for patients.

7. Special Diet Kitchens will be organized and placed in operation on the infirmary and insulin wards so that patients needing therapeutic diets may obtain same.

8. Every effort will be made to eliminate patients from all cooking and food handling jobs due to the inherent danger that accompanies the use of patients in such jobs.

9. There will be a marked extension of the recreational therapy program and a new program of athletic therapy will be initiated. These services will be under the supervision of a paid hospital worker who will be aided and assisted by volunteers.

NURSING SERVICE

Advances made toward modernizing the nursing service during 1949 will be maintained and amplified.

RESEARCH AND EDUCATION

1. All present research and education programs will be carried forward and enlarged upon. Special attention will be paid to the School of Psychiatric Technology which has become an outstanding success.

2. A post-graduate residency training program in psychiatry will be approved and placed in operation during 1950.

3. A program for the clinical training of clinical psychologists will be initiated during 1950. This program will be in conjunction with the University of Arkansas Psychological Training Program.

4. With the aid of the State Department of Education, this hospital hopes to establish a school for feeble minded and mental defective children during 1950.

5. An annual or biannual seminar on psychiatry and psychosomatic medicine will be given by this hospital for the physicians of the state in order to help them with problems encountered in the care and treatment of the mentally ill. A similar program has been requested by the ministers and some school teachers of the state and may be held for such groups if arrangements can be made.

6. Intensive training programs in Job Instruction Training, Job Relation Training and, Work Simplification will be given to all supervisory and subsupervisory employees during 1950. These courses, which will be compulsory will be given with the aid of the State Department of Education.

7. A short, intensive, refresher course will be offered to all stenographers. This course will cover medical and psychiatric dictation, professional spelling, telephone technique, etc.

ADMINISTRATIVE

1. All reorganization and modernization programs begun during 1949 will be continued into 1950. Special effort will be made to make the administrative services of this hospital as effective and efficient as possible.

2. A motor pool will be established during 1950. This unit will be headed by a dispatcher and will operate on a strictly business basis. All cars will be operated on an efficient schedule and special attention will be paid to proper maintenance and repair of vehicles. This change should result in a marked improvement in efficiency and a decrease in operating costs.

3. The hospital center will be remodeled and modernized, and a system of canteen books for patients will be instituted. This will result in better service to patients and a larger income into the center operation.

CONSTRUCTION

1. Plans will be drawn for a new 1,500 bed hospital unit at Little Rock. This unit will be designed as an acute intensive treatment, diagnostic, training and treatment center.

2. The present survey of the psychiatric case load in the State of Arkansas will continue into 1950. It is hoped that when this survey is completed, an adequate estimate of future mental hospital needs will be had and that a definite answer as to where new mental hospitals should be located can be given.

3. During 1950, the new N.P.-T.B. Unit at Little Rock will be placed in operation, as will the new 400-bed ward at Benton and the Meat Curing, Canning, and Cold Storage Plant at the latter unit.

MODERNIZATION AND REFINISHING

1. A continuing drive will be made to clean up and beautify the interior and exterior of all hospital buildings. An all-out push will be made toward painting all wards and patient's rooms and extra effort will be made to install additional latrines, shower rooms, etc.

2. The milk processing building at Baucum will be repaired and enlarged and a new pasteurizing and homogenizing plant will be installed.

3. A concentrated effort will be made to procure more new furniture for all hospital wards and buildings and volunteers will be encouraged to help procure draperies and other interior decorating materials for those units. Special effort will be made to coordinate the needs of the hospital with the vocational training of patients in furniture making, painting, furniture repair, drapery production, etc.

4. A vocational retraining project will be set up to build a 1,000-seat outdoor theatre at Little Rock and a 1,500-seat outdoor theatre at Benton. These theatres will cost little but will allow a maximum of entertainment to reach an exceedingly large group of hospital patients.

IMPROVEMENTS TO GROUNDS AND ROADWAYS

1. A special effort will be made to improve the looks of the grounds at all units. Considerable more attention will be given to grounds, landscaping and roads than has been given these objects in the past.

2. Special shrubbery and tree nurseries will be set up at Baucum and Benton in order that the hospital can be furnished with adequate material for its proposed beautification campaign.

3. As much lawn maintenance and horticulture as possible will be assigned to chronic patients as a community retraining project.

FARM IMPROVEMENTS

1. Every effort will be made during 1950 to build our beef and dairy herds back up to normal and to improve the strain of all farm animals.

2. All soil improvement and soil conservation programs will be continued on through 1950 and special attention will be paid to crop rotation, etc.

3. Maintenance of farm buildings and fences will be made an active, permanent program and will be pushed during 1950.

4. Every effort will be made to increase the quantity and quality of farm production and to decrease waste.

RECOMMENDATIONS OF THE MENTAL HYGIENE COMMITTEE

1. The Medical Society offer the services of the members of the Mental Hygiene Committee to the Crime Study Commission in working out laws covering sex crimes and chronic offenders of all types.

2. The development of an adequate psychiatric service to the penal and correctional institutions of the state, as previously recommended by the Committee.

3. The Committee recommends that a bill be drafted and submitted to the Legislature providing for the establishment of a Board of Psychiatrists to examine all criminal cases where insanity is a plea and the findings of the State Hospital examiners are contested by either the prosecution or the defense.

4. The establishment of a separate institution near one

of the Teachers' Training Colleges in the state for the retarded children requiring institutional care.

5. The mental hospitals in the state are greatly overcrowded. In the future planning, to provide adequate hospital beds for the mentally ill, it is recommended that the Little Rock Unit be planned as the admission, diagnostic, acute treatment, research, and personnel training unit. This unit should not exceed 1,500 beds and should be planned in conjunction with the State Medical Center. Plans should also be prepared for the building of an additional psychiatric unit to be located in some other area of the state, the location to be designated by the Board of Control of the State Hospital. This unit should consist of approximately 500 beds for continued treatment cases of mental illness, as well as approximately 500 beds for geriatric cases requiring custodial and nursing care.

PUBLIC HEALTH COMMITTEE

E. D. McKNIGHT, Chairman

The Arkansas State Board of Health is extremely gratified that one long-sought objective was attained during 1949. No case of smallpox is recorded in Arkansas for 1949. This does not mean that no suspect cases of smallpox were called to attention, but does mean that the director of the division of communicable disease control was able to visit each such case and was helpful in establishing a negative diagnosis of smallpox.

The search for sources of infection of typhoid fever has been continued with considerable success in that fourteen typhoid carriers have been registered for the year 1949. Approximately one carrier was found for each nine cases of the disease since a total of 125 cases were reported.

Malaria and typhus fever investigations are being continued with the aid of a nurse assigned by the United States Public Health Service. Malaria reporting was, in 1949, about one-half what it had been in 1948.

Epidemics of measles and of poliomyelitis were recorded during the year, the latter disease reaching an all-time high in Arkansas, with 989 cases recorded. The case fatality rate was low; no doubt early diagnosis and hospitalization contributed materially to this low rate of less than 5 per cent.

A postgraduate seminar was arranged for the physicians of the state in January, 1949, in cooperation with the Arkansas Medical Society and the Medical School of the University of Arkansas, on the subjects of amebiasis and malaria. Officers of the U. S. Public Health Service and members of the staff of Tulane University Medical School and the University of Arkansas Medical School presented the subject matter.

In 1949, venereal disease control activities in Arkansas stressed two distinct phases which we consider of equal importance in spite of the fact that one is statistically intangible while the other can definitely measure trends in the incidence and prevalence of these diseases.

That part of our program which drew the maximum of attention was the public information campaign which used radio and billboards as the principal vehicles for the distribution of up-to-date materials concerning syphilis, easily the most dangerous of the venereal diseases.

Attractive as this campaign was—and it drew unexpectedly fine comment from public health authorities throughout the United States—it is difficult for us to evaluate its effectiveness other than to say it apparently was favorably received by the general public. It departed from the usual staid methods of public health education and flashed its way throughout the entire state on the flaming colors of Syphilis "pink," accompanied by the radio cowboy singers who told in ballad form of the dangers of contracting a venereal disease. A few of the more conservative folks labelled the program ad "undignified," but it nevertheless attracted the attention of a large portion of the population which was the desired result as outlined in the planning.

A great deal of attention was given to mass blood testing during the past year, particularly in counties where the prevalence of syphilis is high. This was a continuation of a case-finding program which began in 1947, and carried through 1948. This activity serves to find cases of syphilis by sending special blood-testing units into high prevalence areas and through publicity and community organization arranging to take as many blood specimens as possible among the general population. Following the screening process all positive tests are referred to private physicians, or to venereal disease clinics for diagnostic service. Those found infected are placed under treatment. Those who can pay for treatment are referred to private doctors. The medically indigent are sent to Hot Springs Medical Center where treatment is usually completed within five days.

Private physicians and state clinics were looking for venereal disease as diligently in 1949 as in 1948. The overwhelming number of cases is no longer here. These diseases are being wiped out of Arkansas.

The Division of Tuberculosis Control has continued the operation of four mobile X-ray units, and aided in the operation of four stationary X-ray survey units, located at City Health Department, Little Rock; Sebastian County Health Department, Fort Smith; State Hospital for Nervous Diseases, Little Rock; and the University Hospital, Little Rock. A total of approximately 225,000 X-rays were made during the year, and approximately 700 new cases of pulmonary tuberculosis were initially discovered by this means.

The Tuberculosis Case Register has recorded approximately 2,250 cases of tuberculosis which were first reported for the calendar year 1949. These were reported from all sources. A general X-ray clinic has been held in every county in the state during the year, and approximately 450 clinics were held at various locations throughout the state. Most of the case-finding program has been devoted to the medium and smaller size cities and rural areas.

Tuberculosis case-finding will continue as the chief endeavor during 1950, but emphasis will be placed upon the block-by-block chest X-ray surveying of the larger cities in the state: Fort Smith, Pine Bluff, Helena, Hot Springs, and the combined Greater Little Rock area. These five projects would constitute a year's work for the available survey X-ray equipment.

Encouraging gains were made during the year in activities of the Maternal and Child Health Division. Two nutrition consultants and one consultant on hearing and vision testing were added to the professional staff. This is the first full year the vision and hearing testing program has been in operation and has proved to be extremely popular with the schools. The work of the two consultants on our staff is correlated with that of the Division of Speech Education of the State Department of Education and with the Junior League Speech Correction School, and follows recommendations of the Committee on EENT of the Arkansas Medical Society.

The division, in cooperation with the Pediatric Department of the University of Arkansas School of Medicine, sponsored two postgraduate refresher courses. These courses were attended by a total of 252 professional people, 171 of whom were practicing physicians. Also, arrangements were made for a joint project with the Department of Obstetrics of the Medical School.

The services of the dental fluoride team was secured from the U. S. Public Health Service for demonstration of the application of sodium fluoride to the teeth of the

school children as a prophylactic measure in dental caries control. Since the beginning of the demonstrations, complete series of treatments have been given 5,604 children in eight areas in the state. Late in December, 1949, the team moved into Fayetteville, to begin the ninth demonstration.

Under midwife control service, efforts are made to weed out the most unfit midwives and to keep the others under supervision, as well as to educate the public concerning what a midwife can and cannot safely do, and to encourage patients to use supervised midwives. In this connection, 539 midwife permits were issued on recommendation of the medical directors or part-time health officers and public health nurses.

Six nurses employed in local health departments were granted scholarships for basic public health nursing study in approved university programs, four nurses on the state staff either completed or continued advanced study previously begun; ten other nurses from local departments were granted leave for study in short workshops. In-service training programs for all nurses covering two main topics—Services for Crippled Children, and Growth and Development of the Young Child—were conducted by the state nursing staff every other month throughout the year. In May, a Cancer Nursing Institute was held for public health nurses as well as professional workers in related agencies.

The Division of Industrial Hygiene offers engineering, chemical and educational services to manufacturing and processing plants as follows:

1. Finding and evaluating occupational health hazards.
2. Recommendations for controlling the working environment, improving plant health programs and plant sanitation.
3. Educational talks, pamphlets, posters, articles and films.

During the year 1949, 182 plant visits to 167 different plants, 205 recommendations and 147 laboratory and field determinations were made affecting 20,000 industrial workers. Approximately 25 per cent of the recommendations were carried out, and it is anticipated that practically all recommended improvements will be made over a period of time.

In November, 1949, a section of industrial nurses was organized, with the aid of the State Division of Public Health Nursing and personnel of the Public Health Service. This was sponsored in an effort to improve plant medical programs.

The general program for 1950 will be basically similar; however, more emphasis is planned for educational efforts to encourage understanding of the importance of environmental control and for checking plans, before installation, for the control of toxic substances.

The promotional and engineering activities of the Bureau of Sanitary Engineering played an important part in bringing about major improvements and additions to 67 public water systems, and 22 public sewerage systems. These included the construction of complete new water systems for three towns and four new swimming pools. The cost of these improvements and additions was slightly more than $5,000,000. This is an increase of 40 per cent over the cost of similar construction for 1948.

Plans and specifications for major improvements to 27 water systems and 23 sewerage systems were reviewed and approved. The cost of these proposed improvements is estimated at $5,350,000 as compared to $4,300,000 for plans for similar improvements for 1948. Construction is now in progress on a number of large water sewerage improvements, and it is believed that the amount of such improvements will far exceed that for 1949.

Periodic inspections were made of the 203 public and institutional water systems and 115 public sewerage systems.

The Bureau of Sanitary Engineering was active in helping to draft Act 472 of the 1949 Legislature which created the Water Pollution Control Commission. The Commission held its organizational meeting October 27, 1949. Application for Federal funds provided by P. L. 845 was made, and discussion of the Commission's functions conducted. Work by the Commission is limited as no funds were appropriated by the state. Work is being carried on with Federal money received in late December. At present the Commission is compiling data as to sources of pollution, checking sewage works plans, holding conferences with municipalities and industries relative to waste disposal, and working with interested parties on matters of stream pollution. Future work will be the development and activation of an overall plan for water pollution abatement.

Plans were approved by the Division of Milk Control for seven new pasteurization plants. Plans and other information were provided for the construction of approximately 400 new dairy barns. Considerable time was spent in training seven new inspectors and giving partial supervision of sanitarians on milk sanitation. Surveys were made of the milk supplies for twenty-three cities to determine compliance with the state laws.

Pasteurized or Grade "A" raw milk is now available to almost every area of the state. This has increased the need for additional inspection service.

The main functions of the Division of Dairy Products consisted of sanitary inspection of plants, maintenance of composition standards, prevention of fraudulent practices, licensing of and collecting fees from the manufacturing plants, and the general improvement of the manufactured product from the standpoint of health and palatability.

During the year 1949 the Division of Food and Drug Control participated in all of the major programs assigned to its jurisdiction. Greater emphasis, however, was placed on the inspection of school hot lunch rooms, enforcement of the Barbiturate Act, restaurant inspections, and grocery-market inspections. Less than ten per cent of the hamburger samples picked up in the last six months have contained adulterants, as compared to seventy-five per cent of those collected two years ago.

The Malaria Control activities are financed by Federal and local funds. During the year malaria control work was in operation in fifty counties in the state, located principally in the Mississippi, Red River, Ouachita, and Arkansas valleys. A total of 109,328 houses were sprayed during the year. Mosquito control activities were carried on in twenty towns and cities under the direction of the Division.

During the year the Division of Hospitals completed the processing of sixteen projects amounting to $6,700,000, opened bids on these projects and let contracts. Six applications were given preliminary approval amounting to approximately $10,000,000. Five projects were completed amounting to approximately $1,000,000.

For the year 1949, the Bureau of Vital Statistics has accomplished the following:

Brought up-to-date the microfilming program which was approximately one year delinquent.

Provided veterans with approximately 7,000 free copies and verifications of documents on file in the Bureau. This service was never rendered prior to 1949.

Worked in cooperation with the State Revenue Department, Federal Bureau of Investigation, Military Intelligence, National Guard, Girls' Training School, and Labor Division, providing these agencies with photostatic work required.

The Bureau of Vital Statistics has worked with the aim of receiving better birth and death registration in the state.

The last survey by the Federal Government indicated that Arkansas had 70 per cent registration and was rated near the bottom of states listed. We expect the federal survey which is now under way to indicate a 90 per cent registration for the State of Arkansas.

LIAISON COMMITTEE WITH THE ARKANSAS MEDICAL & HOSPITAL SERVICE, INC.

(Blue Cross-Blue Shield)

G. REGINALD SIEGEL, Chairman

The one project of this Committee is to see that prepaid medical, surgical, and hospital coverage is available to every person in the State of Arkansas that desires such coverage.

The Arkansas Medical & Hospital Service, Inc., has some 30,000 persons protected at the end of November, 1949. The enrollment has been limited primarily to groups of employed people; however, 25 county farm bureaus had been enrolled as of November 30th and it was anticipated that some 8 or 10 more bureaus would be enrolled during the month of December, 1949.

The Board of Trustees is considering a plan to extend further the program to individuals beyond those who have memberships in the farm bureaus by offering the program on a wholesale or community basis during specified periods for a previously defined area. It is hoped that this type of operation will be in effect in the early part of 1950.

It is the opinion of the Board of Trustees that Blue Cross-Blue Shield be kept in position to do the greatest good for the greatest number of the people and they hope to extend their membership to some 100,000 persons during 1950.

Blue Cross-Blue Shield is available in every county in the state and needs only the cooperation of the medical profession in each community to help institute groups. This Committee, as well as the Board of Trustees of the Arkansas Medical & Hospital Service, wishes to make it clear, however, that a membership to anyone seeking a membership will not be possible, since, in our opinion, this type of offering can be done only on the basis of a very restricted coverage and a high premium.

The Liaison Committee urges all of the members of the Arkansas Medical Society who are interested in inaugurating this service in their community to contact Mr. J. L. Redheffer, The Arkansas Medical & Hospital Service, Inc., Rector Building, Little Rock, Arkansas.

Chairman Siegel, in amending the published Committee report, stated that the Arkansas Medical and Hospital Service, Inc., now has eight field representatives throughout the state, available at the request of any Society member. Furthermore, it has been suggested that members cooperate in the forming of group plans in their respective areas, such plans now enrolling on an individual basis. The present goal is to bring hospital coverage to at least 100,000 people in Arkansas.

COMMITTEE ON THE AUXILIARY

LOUIS K. HUNDLEY, Chairman

In accordance with the wishes of the President and the Council of the Arkansas Medical Society during this year, the Auxiliary has assumed responsibility for a major portion of the public relations program of the Society. As coworkers on the Committee for the Extension of Medical Care, they have helped plan and implement our Grass Roots program through education of membership, distribution of pamphlets, endorsement campaign, letters to Congressmen, fair and livestock show booths, and the high school essay contest. To say only that they have done a good job is faint praise. If other Auxiliaries throughout the nation do half as good a job the battle against government control of medicine is well on the way to being won.

Under the leadership of the presidents of the past four years, our Auxiliary has grown from twenty-one component groups with 410 members to twenty-five groups with over 700 members. From more or less social groups they have developed into vital forces in our battle against socialism. Some Auxiliaries which met only semi-annually have met monthly during this crisis. Our leaders are receiving national recognition for their work and it is with pride that we note the election of Mrs. Mason G. Lawson as a vice-president of the Auxiliary to the American Medical Association.

I feel that it is imperative for the Society to continue to encourage and support the Auxiliary in carrying out its objectives. Its program must not be allowed to lag because of lack of funds or disinterest on the part of the Society. Every portion of the Auxiliary program has been developed with the full knowledge and support of this Committee. An example of the liaison between members of the executive board of the Auxiliary and the members of this Committee is the submission of written reports from sixty-five of its sixty-eight members on this year's Auxiliary program.

It is with considerable regret that I retire from the Committee at the close of this year. I feel that our Auxiliary has accomplished much and that this work must and shall be carried on. It has been a real pleasure to see this work develop and its strength increase.

My recommendations for 1950-1951 are as follows:

1. All county medical societies which have no Auxiliary are urged to give permission and support to the immediate formation of such Auxiliaries.
2. Allowance of $150.00 for printing of the minutes and reports for the year. (Cost averages $175.00.)
3. Travel allowance of $500.00 for the President and $100.00 for the President-Elect should be continued on a reimbursement basis.
4. Allowance of $25.00 for membership in the Arkansas Legislative League, provided that the Arkansas Medical Society continues its membership.
5. Representation on the Committee for the Extension of Medical Care on a councillor district basis. (One Auxiliary member from each district.)

TRAVEL SCHEDULE, PRESIDENT OF AUXILIARY TO ARKANSAS MEDICAL SOCIETY

April 19-22—Midwest Health Conference, Kansas City.
May 10—First Councillor District Meeting, Tyronza.
May 16—Fourth Councillor District Meeting, Pine Bluff.
June 5-10—Annual Meeting, Auxiliary to the AMA, Atlantic City, N. J.
June 20—Auxiliary to the Southeast Arkansas Medical Society, McGehee.
June 23—Pope-Yell County Medical Society and Auxiliary, Russellville.
Sept. 13—Auxiliary to Garland County Medical Society, Hot Springs.
Sept. 14—Arkansas Health Council, Little Rock.
Sept. 30—Executive Board, Auxiliary to Arkansas Medical Society, Little Rock.
Oct. 9-13—Conferences, AMA offices; Whitaker & Baxter, Chicago, Ill.
Oct. 14—National Conference on Physicians and Schools, Hyde Park, Ill.
Oct. 17—Fourth Councillor District Auxiliary, Monticello.
Oct. 19—Auxiliary to Pulaski County Medical Society, Little Rock.
Oct. 27—Joint Meeting, Auxiliaries to Bowie-Miller, Little River and Sevier County Medical Societies.
Nov. 2-4—Conference of Presidents and Presidents-Elect,

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PRECISION BALL TYPE FLOW METER GIVES CONTINUOUS READING OF CO_2 GAS FLOW FROM O TO 90 CC./MIN.

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The Gasometer consists of a cylinder having a capacity of 100 cc. and a lead-weighted piston. The piston provides the pressure head which delivers the carbon dioxide to the cannula, and the weight of piston is so calibrated that it cannot produce a pressure higher than 200 mm. Hg. In operation, the gas used to perform a test is delivered by the Gasometer. It is not drawn directly from the CO_2 cartridge or the expansion chamber which may have a pressure of several hundred of pounds per square inch. Inasmuch as the Gasometer cannot deliver gas at a pressure higher than 200 mm. Hg. there is no possibility of building up dangerous pressures in the patient's body when the Kidde Tubal Insufflator is used.

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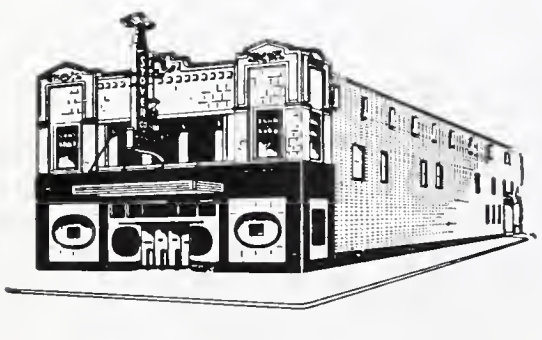
Three applicators, varying in diameter from 5/32 to ½ inch, are supplied with the apparatus. The sleeve of each applicator is specially tapered at the tip so that the pencil of dry ice will not drop out but must be forced out by pressure applied on the plunger. The operator is thus enabled to regulate the speed of renewal of the dry ice at the active tip and to adjust the pressure necessary for refrigeration.

The KIDDE Dry Ice Apparatus brings NEW SAFETY and SIMPLICITY to cryotherapy. With it cryotherapy can be easily applied whenever it is indicated. There is no advance preparation necessary . . . no bother of sending to a drug store for dry ice . . . no large cylinders of gas to be handled and stored.

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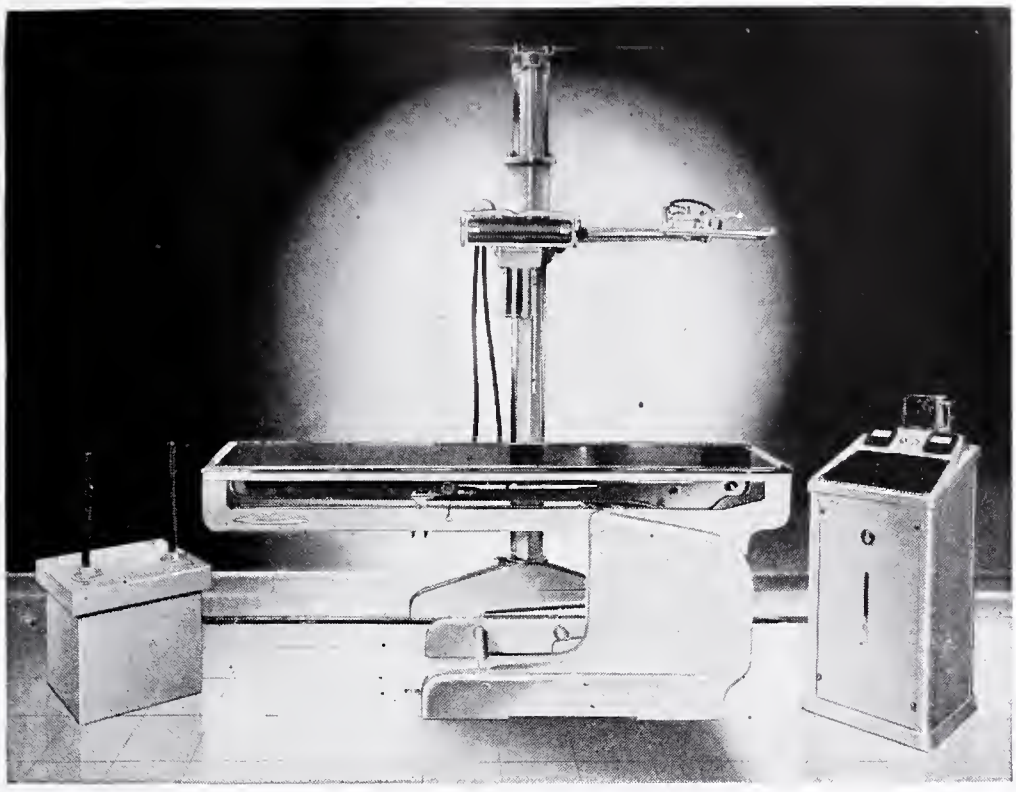
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30 MA

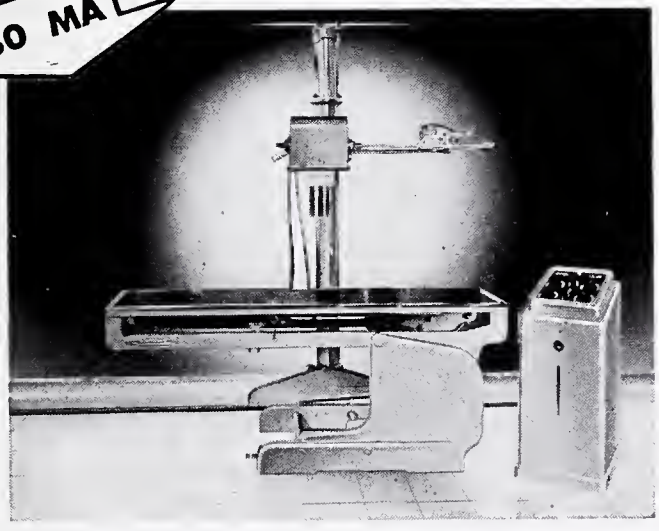


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Auxiliary to the AMA, Chicago, Ill.
Nov. 14-16—Auxiliary to Southern Medical Association, Cincinnati.
Dec. 1—Arkansas Health Council, Little Rock.
Dec. 2—Auxiliary to Jefferson County Medical Society, Pine Bluff.
Dec. 7—Auxiliary to Union County Medical Society, El Dorado.
Jan. 9—Auxiliary to Sebastian County Medical Society, Fort Smith.
Jan. 17—Auxiliary to Arkansas County Medical Society, Stuttgart.
Feb. 1—Auxiliary to Greene-Clay County Medical Society, Paragould.
Feb. 1—Craighead-Poinsett County Medical Society and Auxiliary, Jonesboro.
Feb. 10—Executive Board, Auxiliary to Arkansas Medical Society, Little Rock.
Feb. 21—Auxiliary to Columbia County Medical Society, Magnolia.
March 2—Auxiliary to Ouachita County Medical Society, Camden.
March 9—Auxiliary to Washington County Medical Society, Fayetteville.

In addition to the aforementioned trips I have scheduled visits to Auxiliaries to the Jackson, Hempstead, Monroe, and Hot Spring County Medical Societies. Because of conflicting engagements I was unable to accept the invitations of the Ninth Councillor District and Second Councillor District. I have attended twenty-two committee meetings on Auxiliary business in Little Rock, and have been present at all meetings of the Committee for the Extension of Medical Care.

REPORT OF THE AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY

The Auxiliary to the Arkansas Medical Society has celebrated its Silver Anniversary year by achieving a greatly increased membership; by intensifying its effort in every field of the established program; and by formulating and implementing a program of public relations aimed at combatting compulsory national health insurance.

Following the April convention the Auxiliary had its first workshop for training state officers and committee chairmen, and county presidents. Work books containing detailed plans for the year's activities were distributed. Much of the integration of state and county auxiliary programs may be attributed to this session.

At the request of Dr. Euclid Smith, the Auxiliary assisted in establishing the Arkansas Health Council. The president attended the Midwest Health Conference and later visited the offices of the AMA where the Bureau of Health Education provided much material to aid in this project. Dr. D. A. Dukelow was sent to Arkansas by the AMA to assist lay groups in their first state-wide rally for setting up the Council.

The Auxiliary is approaching the goal of $5,000 for the Ilse F. Oates Student Loan Fund, with $4,053.12 now in the fund, and contributions from several Auxiliaries still unreported. The seventy-fifth medical student has recently received a loan from this source. Two loans have been made to student nurses from the Martha Harding Gann Memorial Loan Fund.

Each Auxiliary in the state has made plans for the observance of Doctor's Day, and Governor Sid McMath has proclaimed March 30th for this occasion. Tributes will be paid over the radio, in the newspapers, and from the pulpit to members of the profession. Although many social affairs will be given to honor physicians, the Auxiliary is emphasizing this date as an opportunity for the establishment of better understanding between the doctors and the laity.

Attempting to attain a unified, systematic organization each component group has been urged to adopt a Constitution and By-Laws patterned after that of the state Auxiliary. Each county organization has been advised of the necessity for an advisor from its county medical society.

The Auxiliary continued to contact organizations throughout the state for contributions for the Erle Chambers Memorial Library Fund, which purchases books for the libraries at the tuberculosis sanatoria.

Auxiliaries furthered their public relations programs by assisting volunteer and tax-supported health groups in the tuberculosis screening program, Seal Sale campaign, Red Cross, cancer control program, March of Dimes, and PTA pre-school roundups. They provided material for health programs before civic clubs and PTA groups.

Hygeia promotion has placed that magazine in many doctors' waiting rooms, beauty parlors, schools, and libraries.

A history of the first twenty-five years of the Arkansas Auxiliary is being compiled by the historian, and biographies of pioneer doctors are nearing completion.

The work of the Auxiliary on the program for the Extension of Medical Care was our outstanding endeavor. Members received information on pending legislation, on Blue Cross-Blue Shield, and the AMA Twelve Point Program. Pamphlet distribution covered drug and grocery stores, beauty parlors, libraries, and club meetings. Many groups purchased copies of "The Road Ahead" for school and public libraries.

An endorsement campaign was conducted among women's groups throughout the state, and letters were secured from members and their friends on legislation affecting medicine. Booths were set up at thirty county fairs, two district livestock shows, and the state livestock show to distribute campaign material. There were booths at the Tri-District Lions' Convention, the Business and Professional Women's nine-state conference at Hot Springs, and at the Arkansas Farm Bureau Convention. Approximately 500,000 pieces of literature were given out at these booths.

An Essay Contest was conducted in high schools throughout the state under the auspices of the Auxiliary. Results will be announced at the state convention.

To have served as the leader of 700 women devoted to the cause of independent medicine is a privilege for which I shall ever be grateful. It is with sincere appreciation for the effort of each member that I summarize our accomplishments of 1949-1950. We have received the utmost in encouragement and assistance from our Advisory Council.—(Mrs. Louis K.) Jeane D. Hundley, President, Woman's Auxiliary to the Arkansas Medical Society.

As an addendum to his Committee's published report, Chairman Hundley presented to delegates a resume report on biographies of pioneer Arkansas doctors, published in issues of The Journal of the Arkansas Medical Society, as compiled by Mrs. Charles W. Dixon, Chairman, Biography Committee, Woman's Auxiliary to the Arkansas Medical Society:

Eight years have passed since the compilation of the History of the Pioneer Doctors in Arkansas was undertaken, at the request of the American Medical Association and the Arkansas Medical Society, for publication in The Journal of the Arkansas Medical Society.

In 1943, it was decided at the fall Board meeting of the Auxiliary that the pioneer period in the medical history of Arkansas should end in 1881, the date of the first register of physicians and surgeons in each county in Arkansas.

Prior to 1943, only one Pioneer Doctors History had

been compiled and published, that of Lincoln County in 1942.

A period of six years elapsed before anything else was published.

This type of work is not easy, but it is up to the doctors' wives to accomplish this. Our Pioneer Doctors deserve this honor.

In May, 1948, Pulaski and Sebastian Counties were published. Sebastian was incomplete.

Since January, 1949, data has been published on the Pioneer Doctors in the following counties: Garland, Independence, Searcy, Monroe, Newton, Carroll, Boone, Baxter, Sevier, Bradley, Jefferson. More data is needed in several of these counties.

Ashley needs completion, and Desha is ready for publication. These are both holdovers.

Since January 1, 1950, the following have been received: Pike, Howard, Union, Independence, Clay, Washington, Yell, Grant, Faulkner, Perry and Lonoke.

Some of these are incomplete, but all are of great interest.

It was this evidence of an awakening interest which influenced me to carry on another year, hoping that every county will be completed by April 1, 1951.

It is to be hoped that every doctor's wife will lend her aid in this work during the coming year.

References where many of these records are to be found are included in this report, to assist those who are interested in their work, particular attention being stressed on the Goodspeed publications of 1889-1890, etc., and to the County Registers of 1881.

References:

Hempstead's History of Arkansas, 3 volumes.

Publications of the Arkansas Historical Association.

Arkansas Historical Quarterly.

Centennial History of Arkansas (Biographical).

Pioneer Tales of Eureka Springs and Carroll County, by Cora Binkley Call, 116 pages, 1903.

Biographical and Historical Memoirs of Arkansas, published 1889-1890, by Goodspeed Publishing Company.

Biographical and Historical Memoirs of Northeast Arkansas, Goodspeed Publishing Company.

The Mid-South and Its Builders, Chas. P. Mooney, Editor, published by Mid-South Biographic and Historical Assn., 1930. (This takes in Arkansas, Mississippi and Tennessee.)

Biographical and Historical Memoirs of Western Arkansas, Southern Publishing Co., 1891.

Biographical and Historical Memoirs of Eastern Arkansas, Goodspeed Publishing Company, 1890.

One Hundred Years of Fayetteville, 1828-1928, W. S. Campbell.

First One Hundred Years in Johnson County, by Ella Molloy Langford.

Biographical and Pictorial History of Arkansas, Vol. 7, (all published) 581 pages, John Hallum, 1877.

The Scrapbook of Arkansas Literature, 1939, from which Dr. Frank Vinsonhaler compiled his data on "Early Doctors in Arkansas."

"Early Days in Fort Smith," compiled from the Southwest Times Record Centennial Edition, July 19, 1936, beginning with a sketch of "Dr. Bailey, Pioneer Physician of Fort Smith," Phebe Park, Jr., 24, Vols. 1, 2 and 3.

A Sketch of Napoleon, Arkansas, and Marine Hospital, taken from the notes of Dr. Charles M. Taylor, property of Mrs. Charles M. Taylor, Little Rock, January 1, 1938.

Diplomas in the Library of Arkansas School of Medicine.

Blytheville Courier News, Centennial Edition, July 1, 1936, Sections E and D.

County Histories, recently published, and other County Centennial Editions.

Histories of Lawrence, Jackson, Independence and Stone Counties of the Third Judicial District of Arkansas, by Sallie Walker Stockard of the Little Rock Democrat Co., 1904, 204 pages.

History of Scott County, by Henry Grady McCutcheon, 74 pages, H. G. Pugh Co., 1922.

Arkansas History Commission, records at State Capitol, see Mr. Dallas Herndon.

Old College Records, etc.

County Registration of Physicians, 1881.

Tombstone inscriptions.

Newspaper obituaries.

Family Bibles.

Respectfully submitted,

(Mrs. Chas. W.) Evelyn T. Dixon
Chairman, Biography Committee.

COMMITTEE ON PUBLIC RELATIONS

CHARLES R. HENRY, Chairman

At the first meeting of the National Education Campaign of the AMA in February, 1949, we were fired with enthusiasm and supplied with ammunition to launch a modest but fairly successful Public Relations Program in this state. Through the efforts of Dr. W. R. Brooksher, the Secretary of the Arkansas Medical Society; Dr. R. B. Robins, and members of the Committee, the medical profession of the United States turned the tide of rising socialism by defeating the Administration's scheme to create a Department of Welfare.

American Medicine has been in a more favorable position to wage an aggressive campaign against socialism since that time. The Arkansas Medical Society was responsible for the organization of the Western States Medical Conference (composed of the states west of the Mississippi). Doctor Brooksher was unanimously elected secretary at the Denver meeting in January.

The Extension of Medical Care Committee and the Woman's Auxiliary have performed a heroic task of bringing Medicine's message to the people of Arkansas. In the "Analysis of Pamphlet Distribution in Relation to Population" compiled by Whitaker & Baxter, Arkansas has a high score of 100 per cent (exceeded only by Nevada with 101 per cent). This means that nearly two million pieces of campaign literature were distributed in this state.

Mr. W. F. Mitchell, one of the field representatives of Whitaker & Baxter, came to talk with the E. M. C. Committee and work with our Executive Secretary, Mr. Sid Wrightsman. Securing endorsements is another objective of the campaign. On January 31, 1950, Arkansas had 49 organizations on record against socialized medicine. It is a masterpiece of achievement that as of April 4, 1950, we have 206 organizations on record against socialized medicine. Arkansas ranks in the top seven states of the country in the endorsement drive.

Radio programs have been sponsored by various county societies. Speakers have appeared before lay and medical groups. Meetings have been held with the Arkansas Press Association. Large and professional groups have been indoctrinated to Medicine's cause in several areas of the state.

The Arkansas Medical Society through the Public Relations Committee is represented on the Arkansas Health Council by the E. M. C. Committee, the Woman's Auxiliary and the Rural Health Committee. It is my opinion that the Community Health Council offers one of the best channels for the medical profession to show its intent to

bring better health care to the people of our state. Lack of participation in and leadership of the Council means that the practice of medicine will be captured by lay groups and no longer be under the control of the medical profession. I urge all physicians to participate in the Community Health Council and to explore every technique for improving the health care of their people. The Community Health Council movement is gaining momentum in this State and it is the responsibility of the Arkansas Medical Society to see that it accomplishes its proper function. A golden opportunity awaits you.

I want to thank the members of the E. M. C. Committee for their untiring work; and to the Woman's Auxiliary, my sincere thanks and appreciation for their cooperation, support, and achievements. To Doctor Brooksher, Doctor Robins, Doctor Rhinehart and Doctor Shuffield, my thanks for their advice and guidance during the past year. My thanks to Mr. Sid Wrightsman for his willing cooperation in getting news letters out, and the many tasks asked of him.

Even though we look with pride on our accomplishments of the past year, we are saddened by the fact that we have achieved this work with 50 per cent cooperation. We could have done twice as much.

Recommendations:

1. Again, I strongly feel that we would profit by employing someone with Public Relations training to carry out this program.

2. Should this be too ambitious, it seems to me that additional help might be secured for the Executive Secretary so he could spend more time out in the state.

3. The full cooperation of the Public Relations Committee for the coming battle at the polls.

4. Continue strong endorsement drive.

5. Literature distribution.

6. Speakers' Bureaus.

7. Radio programs.

RURAL HEALTH COMMITTEE

JOE W. REID, Chairman

The Rural Health Committee during the past year has:

1. Sponsored exhibits at county fairs throughout the state and distributed literature supporting the private practice of medicine and the state Blue Cross-Blue Shield program.

2. Attended all meetings in the state which were held to organize the Arkansas Health Council.

3. Sent representatives to the Fifth Annual Conference on Rural Health, sponsored by the American Medical Association, held at Kansas City in February, and on the program of which were three Arkansans representing state lay organizations.

4. Formulated plans for the launching of a physicians' placement bureau to locate doctors in the state where such a need exists.

Recommendations:

1. Increased Society participation in the organizing of county health councils.

2. The full cooperation with and support by the Society of the University of Arkansas Extension Department on Health Education on behalf of our rural people. In addition, a vote of appreciation by the Society to Mr. Aubrey Gates and Miss Helen Robinson, health specialists with the Extension Department, for the outstanding work they have done in organizing the Arkansas Health Council.

3. Increased attendance of Society members at the Annual Conferences on Rural Health.

POSTGRADUATE STUDY COMMITTEE

A. D. GARNER, Chairman

At the annual meeting of the Arkansas Medical Society in April, 1949, it was decided that the Committee on Postgraduate Medical Study should be transferred to the Committee on Medical Education and Hospitals as a subcommittee. This transfer was accomplished and approved by vote in the House of Delegates. On September 14, 1949, it was announced that the Committee should consist of Dr. A. D. Garner of Paragould, Dr. Jeff Banks, and Dr. D. A. Rhinehart of Little Rock, and Dr. E. J. Stroud of Jonesboro.

The Committee sponsored a postgraduate course in Pediatrics given by the Department of Pediatrics of the University of Arkansas School of Medicine under the supervision of Dr. William A. Reilly at Little Rock on October 31 and November 1, 1949. The Committee collaborated with the First Councillor District Medical Society in presenting six outstanding medical speakers and the president of Hendrix College at an afternoon and evening meeting in Paragould, November 8, 1949. Dr. James Costen of St. Louis opened the meeting with a paper on the Morphology and Diagnosis of Tumors of the Larynx. Dr. Paul Mahoney of Little Rock discussed the paper. Dr. Thomas Findley of New Orleans introduced the subject of the Management of Generalized Edema, and this paper was discussed by Dr. Richard Ching of Memphis. Dr. Alton Ochsner of New Orleans spoke on the Diagnosis and Treatment of Bronchiogenic Carcinoma. Discussion on this subject was led by Dr. Duane Carr of Memphis. Supper for the Doctors and their guests was served at the Kingsway Club. In the evening Dr. Matt Ellis, president of Hendrix College, addressed an open meeting of the doctors and lay people of the community. Both the Pediatrics course in Little Rock and the First Councillor District Meeting in Paragould were well attended.

The Department of Pediatrics of the University of Arkansas School of Medicine has scheduled another postgraduate course in Pediatrics for March 13 and 14, 1950, in Little Rock. The Department of Obstetrics and Gynecology of the University School of Medicine is planning to hold a Postgraduate Course in Obstetrics and Gynecology in Little Rock, March 27, 28, and 29, 1950. Registration for the latter course will be restricted to a small number of physicians so that study may be intensive and well supervised.

Recommendations:

1. It is recommended that Committee appointments for the following year be announced in April immediately after the Annual Meeting of the Society so that the chairmen and members of the Committees may accomplish something in the way of planning and organization before autumn. Since appointments are made September 14th, and final committee reports must be in by February 10th of the following year, little time for committee work is allowed.

2. It is again recommended that ten members be appointed to the Committee on Postgraduate Study, two members for five years, two members for four years, two members for three years, two members for two years, and the remaining two members for one year each. It is recommended that two new members be appointed each year to replace those retiring, newly appointed members to serve five years each. This arrangement will give a more permanent organization so that long-range plans for postgraduate medical study may be considered. It is further recommended that two members of the Committee be appointed from each of the four corners of the state and the remaining two members be appointed from the central part of the state. This will allow the local committee mem-

bers to set up postgraduate study sessions in their own part of the state, thus bringing speakers nearer to those physicians who may be interested in attending the meetings.

CANCER CONTROL COMMITTEE

HENRY G. HOLLENBERG, Chairman

The Committee on Cancer Control has worked throughout the year with the complete cooperation of many other agencies and individuals with whom it is associated. Prominent amongst these are the Arkansas State Cancer Commission, the Arkansas State Cancer Society with its Field Army and the various Cancer Clinics and their physicians throughout the state.

Your Committee has arranged four Seminars which were held in November in Fort Smith, Texarkana, Jonesboro and Little Rock. Prominent out-of-state speakers held these Seminars which on the whole were satisfactorily attended and were thought to be quite successful. This type of Seminar was tried this year for the first time and it is thought that something of the same sort should be continued each year to come. Along the same line we have been instrumental in obtaining the services of a prominent speaker for the state meeting to be held in April, 1950. In carrying out the above two programs we are indebted to the State Cancer Commission for financial assistance and to many physicians and other agencies for the real success and management of the program.

It is felt that through the many agencies throughout the state carrying on this work that every individual in the state having cancer can obtain modern and adequate therapy of all types regardless of his financial condition.

MATERNAL WELFARE COMMITTEE

I. FULTON JONES, Chairman

The Maternal Welfare Committee held a meeting September 18, 1949, Albert Pike Hotel, Little Rock, Arkansas. At that time, Dr. Willis E. Brown, Professor and Head of Department of Obstetrics and Gynecology, University of Arkansas School of Medicine, offered a plan of graduate education through the Medical School and Public Health Services for Obstetrical Refresher Courses. This was approved by the Committee and the first Bedside Refresher Course will be held in March, 1950. It is expected that about fifteen men will receive this course, which will last three days.

Dr. Brown, also, offered Consultation Services by telephone or even actual bedside by his staff, to any interested physician in Arkansas.

The Committee was pleased to note that maternal deaths in the past two years showed a further decrease in maternal mortality. Committee feels that any further decrease in maternal mortality will have to come after the needs of maternal hospitalization for indigents throughout the state has become possible.

CHILD WELFARE COMMITTEE

JOHN T. GRAY, Chairman

The Committee on Child Welfare met on several occasions during 1949-50 with a quorum being present at each meeting. A number of urgent problems in child health and welfare was presented to the Committee and the following action with respect to each problem was taken:

PREMATURITY

The Committee recommends that in order for the Statistical Division of the State Health Department to secure adequate statistics on premature births that all physicians be urged to complete birth certificates to show accurate birth weights.

SCHOOL HEALTH SERVICES

It is the feeling of this Committee that the Society should endorse school health programs and urge school systems to establish and operate such a program. To this end the Committee recommends that each county medical society appoint a school health committee from among its members to advise with and provide medical guidance and leadership to any school system contemplating the establishment of, or having in operation, a school health program, and to work with the local health department in this program. Such committeemen would also serve, it is hoped, as representatives of the medical profession on community health councils, school advisory health councils, or as school physicians.

POLIOMYELITIS

On December 15, 1949, a Report of the Special Committee on Poliomyelitis of the Pulaski County Medical Society was received by this Committee with the request that all aspects of the report be carefully reviewed and a report be made to the Society as to its adoption.

This report concerns the general methods of handling patients with acute poliomyelitis when referred to the Little Rock area, and sets up a fee schedule for the care of the acute cases and also fees for convalescent care and subsequent pre-operative and post-operative care. These fees to be paid by the various county chapters of the National Foundation for Infantile Paralysis, Inc., for only those patients considered medically indigent. Representatives of the NFIP from the state and national level advised this Committee of their policy regarding medical services. They wish to assist in every possible way the mobilization of equipment and personnel to provide the best medical care for the polio patients at all times, particularly during an epidemic and in so-called epidemic areas. Where the polio patient has need of financial assistance the county chapter may agree to pay all or part of the cost of hospitalization, nursing care, drugs, ambulance, braces, physical therapy, or convalescent care. A family thus relieved of this tremendous cost would, it is anticipated, be in a position to pay their own doctor bills.

With regard to the report under discussion, the representatives of NFIP were generally in agreement with paragraphs 3 and 4. Paragraphs 1 and 5 of the report disregards those cases known to be medically indigent and at present are treated by the Crippled Children's Division of the State Department of Public Welfare. It is the Committee's opinion that NFIP would prefer this arrangement to continue, with some provision being made to compensate the physicians concerned. They object to paragraphs 5, 6, and 7, stating the schedule of fees is too high and suggest a fee schedule not to exceed the South Dakota plan.

In view of the objections to the Report of Special Committee on Poliomyelitis of the Pulaski County Medical Society by the NFIP, this Committee recommends that the report not be adopted by the Arkansas Medical Society.

In lieu of the report under discussion, your Committee recommends that the following statement of policies with regard to care and treatment of infantile paralysis be approved by the Society:

1. Professional individuals and groups, hospitals, and official state and voluntary agencies have responsibilities to the patient with poliomyelitis and should coordinate their energies and resources in a unified approach to the problem of making care available to those who need it. Activities of such groups whether they be public, voluntary, or private, local, or state-wide, can be directed by the

State Poliomyelitis Planning Committee which was organized and functioned in the 1949 epidemic.

2. The program of care should be so planned as to maintain contacts between patient and family and in such a manner that it preserves the doctor-patient relationship. Cases of known or suspected poliomyelitis referred to a distant treatment center, should be directed to a specific hospital, physician, or agency by the family physician if at all possible. Only one physician should have the primary responsibility of the patient at all times. Other physicians seeing the case should be on a consultant basis.

3. Hospital facilities for acute and convalescent care should be increased by encouraging the general hospitals in the larger cities of the state to accept and care for poliomyelitis patients.

4. The following schedule of fees be submitted to all concerned as a fair and adequate reimbursement for services to the medically indigent poliomyelitis and poliomyelitis suspect patient whose cost of care is underwritten by the NFIP county chapters.

Hospitalization: County chapters of NFIP will pay hospitals for care of poliomyelitis patients at inclusive reimbursable cost rates as maximum payment, except in those instances where it is agreed that a negotiated rate (less than cost) is in order.

Convalescent Care: County chapters of NFIP will pay convalescent homes for care of poliomyelitis patients at inclusive reimbursable cost rates as maximum payment, except in those instances where it is agreed that a negotiated rate (less than cost) is in order.

Nursing Care: Except in unusual circumstances, nursing service is to be a part of the inclusive care provided by hospitals. In these unusual instances the usual rates of private duty, or practical duty nursing fees could not be exceeded.

Physical Therapy: Received as in-patient care this service would be absorbed in the inclusive rate of hospital or convalescent center. For physical therapy given as an outpatient by a qualified physical therapist the fee shall not exceed $2.00 per treatment.

Physicians: The physician's fee for the care of an anterior poliomyelitis patient, not developing bulbar complications, shall not exceed $50.00 for the first full month of illness, or $3.00 per visit, not to exceed $12.00 per week during the acute state if the patient be dismissed prior to the end of the first full month.

The physician's fee for the care of an anterior poliomyelitis patient developing bulbar complications shall not exceed $85.00 for the first full month, or $3.00 per visit not to exceed $21.00 per week during the acute stage if the patient be dismissed prior to the end of the first full month.

The physician's fee for hospital supervision of a patient subsequent to the first month of illness shall not exceed $15.00 per month. (An exception to this provision should be considered by local chapters in certain rare instances when the development of respiratory or other unusual complications make additional care necessary.) In these cases the doctor will be asked to set forth, with sufficient clarity, an explanation of such additional services.

When consultation is necessary, the consultant, who must be a licensed physician and surgeon qualified in his particular specialty, may be chosen by the attending physician. A fee of $5.00 will be paid for initial and subsequent visits, such fee not to exceed $12.00 for any one week except as shown above.

Surgical fees include the necessary pre- and post-operative care and may be over and above the honorarium received from the Crippled Children's Division for general supervision of these cases.

For major operative procedures requiring anesthesia and open surgery, regardless of the number of procedures done during the operation, the surgeon's fee shall not exceed $75.00.

Anesthesia: The anesthetist's fee shall not exceed $10.00 for the first hour, nor more than $5.00 per half hour thereafter.

Follow-up care will be accomplished through the clinics of the Crippled Children's Division at no cost to the county chapter or families.

Physicians will be expected to itemize accounts for which the National Foundation Chapters may agree to accept responsibility and the acceptance of payments made in keeping with this schedule shall be considered as payment in full for such services.

LIAISON COMMITTEE WITH THE ARKANSAS STATE BOARD OF HEALTH

W. B. GRAYSON, Chairman

The State Board of Health in Arkansas was established by Act No. 96 of the 1913 Legislature. This Act was entitled "An Act for the Better Protection of the Public Health, and for Other Purposes." The power was conferred upon the State Board of Health to make "all necessary and reasonable rules and regulations for the protection of the public health, and for the general amelioration of the sanitary and hygienic conditions within the State, and for the suppression and prevention of infectious, contagious, and communicable diseases, and for the proper enforcement of quarantine, isolation, and control of such diseases."

The general consensus in Arkansas as well as in other states is that this can best be accomplished through the establishment of full-time local health departments, adequately staffed with well-trained physicians, nurses, sanitarians, and other ancillary public health workers. At the present time there are two city health units, eight single county health units and seventeen district health units of from two to five counties each, and ten counties organized for nursing service only. The State Board of Health has not been able to establish and maintain adequate local health service throughout the state because of the following:

1. We have not been able to secure the services of professional personnel, principally physicians and nurses, because our salaries have not been high enough to attract them.

2. Local units of government have not been able to bear their proportionate share of the expenses of conducting a local health program.

As of January 1, 1950, we had only nine full-time local health officers and one assistant health officer in the City of Little Rock. To adequately cover the state we would need a minimum of thirty-one full-time local health officers. At the present time our salary ranges from $5,100 per annum for the untrained physician with no experience in the field of public health to $6.900 per annum maximum for the physician with a year of postgraduate training in public health and several years' experience. The salary range in surrounding states for similar positions is from $o,000 to $6,600, up to $7,500 to $8,400 per annum. On January 1, 1950, we had a total of 100 full-time public health nurses. We would need at least 400 public health nurses to adequately serve the state. In addition to the above we need approximately 130 sanitarians and 130 clerical workers. At present we have fifty-four sanitarians and eighty-four clerical workers. In at least three areas of the state there is a need for the service of a full-time sanitary engineer. The services of full-time veterinarians

are also needed in two or three places. In addition to the above, there is a need for public health educators and nutritionists, and also a number of full-time dentists and dental hygienists. The services of physicians are also needed on part-time basis to conduct pre-natal clinics, well-child conferences, and venereal disease clinics.

The above named personnel and services can be provided for approximately $1.50 per capita. At the present, approximately $981,000 is being expended for local health service in the state.

In order that local units of government might provide their proportionate share of the expenses of conducting a local health program, there needs to be a provision made for them to vote a millage specifically for public health purposes.

The greatest single need is that of securing the services of physicians as full-time health officers, and this problem can only be solved by providing better salaries.

COMMITTEE FOR LIAISON WITH THE STATE HOSPITAL FOR NERVOUS DISORDERS

R. V. McCRAY, Chairman

After a conference with other members of the Committee and investigation of affairs and conditions we find the State Hospital to be in good state and relations with other members of the profession.

There are probably some changes that could be made to better conditions which will be looked into at a later date. At this time we have no definite recommendations to make.

HOSPITAL RELATIONS COMMITTEE

A. S. KOENIG, Chairman

Upon the recommendation of the American Medical Association that state societies appoint committees on Hospital Relations, this Committee was so appointed this year for the first time in the history of the Arkansas Medical Society. With the increased participation of hospitals in offering medical services to patients, it has become mandatory on both national and state levels that the legal and ethical limits of medical practice be clearly defined, and in this respect also, the responsibilities of the physician and the hospital should be separated. In as much as the Committee on Hospital Relations is a new one, its members felt that our objectives for the year 1949-1950 were twofold. Our first responsibility was to propose for adoption by the House of Delegates of the Arkansas Medical Society, a statement of policy which is to be considered the official attitude of the Arkansas Medical Society toward physician-hospital relations. Secondly, to discuss ways and means of settling differences of opinion and grievances which may arise between hospitals and physicians in the State of Arkansas.

The Hospital Relations Committee has been in correspondence with the office of the Attorney General of Arkansas in an effort to obtain a clear definition as to what constitutes the legal practice of medicine, and whether or not hospitals legally have the right to offer medical services. The correspondence has been particularly concerned with the specialties of Pathology, Radiology, Anesthesiology and Physical Medicine, inasmuch as these are the usual medical services offered by hospitals. As yet no final opinion has been forthcoming from the Attorney General, but through further conferences it is our hope that we may have a definite, conclusive opinion as to the legal status of these specialties in the state. The following preliminary opinion, however, has been rendered to this Committee by the Attorney General's office: "In view of the fact that requirements necessary to obtain a license to engage in the practice of medicine in this state are of a personal nature, all of the statutes requiring some quality or characteristic which would not be found in a corporation, we feel that our Supreme Court would adopt the holding in the Kerner case above cited; and it is therefore our opinion that the statutes pertaining to the issuance of licenses for the purpose of practicing medicine could not be extended to include a corporation. Therefore, a corporation, as such, being unable to obtain a license, would not be permitted to engage in the practice of medicine."

The ethical position of the physician in relation to the practice of Pathology, Radiology, Anesthesiology and Physical Medicine has been clearly defined in the report of the Committee on Hospitals adopted by the House of Delegates of the American Medical Association June 6, 1949. In this report it is stated that the Principles of Medical Ethics of the American Medical Association conclude that the overall policy of the American Medical Association shall be that it is unethical for any lay corporation to practice medicine and to furnish medical services for a professional fee which shall be so divided as to produce profit for a lay employer, either individual or institutional, including hospitals and medical schools.

It has become rather a common practice in the present-day management of hospitals to divert profits from Laboratory, X-ray Departments, Anesthesiological and Physical Therapy Departments to cover deficits existing in other portions of the hospital. In some instances this has resulted in exploitation of these departments in the effort to provide a larger margin of profit to help defray expenses of other departments in the hospitals.

Oftentimes fees for the services rendered by the departments of Radiology, Pathology, Anesthesiology and Physical Medicine are established without consultation with the head of the department or the Medical Staff. Also, physicians who head these various departments are employed or discharged without consultation with the Medical Staff.

In view of the ethical principles of the American Medical Association stated above, the Committee also felt that in insurance programs, particularly the Blue Shield and Blue Cross programs which are partially sponsored by physicians, that hospitalization benefits should cover hospital services only. In the present Blue Cross insurance policy which is being issued in Arkansas, provision is made for Laboratory, X-ray and Anesthesiological services to be provided by the hospital. Although it is not the intent of the Blue Cross plan to provide these services for diagnostic purposes on patients who otherwise would be treated as private out-patients, the fact that the coverage is included in the policy has a tendency to make hospitalization for diagnostic purposes more desirable for the insured. This Committee feels that offering these services under the Blue Cross coverage is wrong for two reasons: first, it has a definite tendency to be discriminatory against the private individual practice of Pathology, Radiology, Anesthesiology and Physical Medicine; secondly, it has a tendency to unnecessarily fill hospital beds which are badly needed for patients actually requiring hospitalization.

After due consideration the Committee on Hospital Relations makes the following recommendations to the House of Delegates of the Arkansas Medical Society with the suggestion that they be adopted as the official policy of the Society:

1. That the Arkansas Blue Cross policy shall provide payment for hospital services only. Payments for all of the medical services including Pathology, Radiology, Anesthesiology and Physical Therapeutic services shall be included in the Blue Shield policy.

2. That so far as possible the medical costs of hospital

care be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.

3. That a basic principle in an establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor the physician rendering the service shall exploit the patient or each other.

4. That fees for medical services, which are collected by the hospitals, be established with a representative committee of the Staff to include the Head of the Department, the Administrator and the Executive Medical Staff.

5. That the basis of financial arrangement between hospitals and physician may be salary, commission, fees, or such other method as will best meet the local situation with due regard to the needs of the patient, the community, the hospital and the physician.

6. That bills for all medical services be rendered in the name of the physician or physicians performing the services.

7. That the heads of departments of Radiology, Pathology, Anesthesiology and Physical Medicine be only selected by hospitals in accordance with the accepted methods of appointment of physicians to staff positions in other specialty services of the hospital. Their qualifications for their position should be subject to the approval of the Governing Medical Staff. By the same token, no physician heading a department of Radiology, Pathology, Anesthesiology or Physical Medicine shall be separated from staff appointment by the Administrator or Governing Board of a hospital without the knowledge or approval of the Governing Medical Staff.

In respect to the second objective of the Committee on Hospital Relations, it was felt that any grievances or differences of opinion which might arise between physicians and hospitals should first be discussed at the local level with the assistance of the local County Medical Society. For this reason it is suggested that where indicated, committees on Hospital Relations should be established within local County Medical Societies. The Committee on Hospital Relations of the State Society will be available to receive complaints from any physician, hospital, medical organization or any other interested person or group with reference to professional or economical relations existing between Doctors of Medicine, hospitals or medical schools. If settlement of differences of opinion fail at the local county level, upon receipt of the written complaint by the state committee, the matter shall be investigated and acted upon in such a manner as the Committee may decide and in accordance with regular and existing modes of procedure. If an arbitration cannot be effected by the Committee on Hospital Relations or the Council of the Arkansas Medical Society, the matter will be referred to the Judicial Council of the American Medical Association. The American Medical Association has stated that if a hospital or other lay group is found guilty or will not cooperate within ethical and legal limits, the Judicial Council shall order the withdrawal of the Association's approval of the institution concerned.

The recommendations herein included have been submitted to the Arkansas Society of Radiology and the Arkansas Society of Clinical Pathologists and were unanimously endorsed by both of these organizations.

The Chairman wishes to thank the members of the Committee on Hospital Relations, as well as the Chairman of the Committee on Medical Education and Hospitals and Officers of the Arkansas Medical Society for their interest and cooperation.

Chairman Koenig, adding to his Committee's published report, stated that the Committee had been unable to get an opinion from the Attorney General of the State in regard to the hospital practice of medicine. He added that the Committee recommends that a new medical practice act be presented to the 1951 Arkansas Legislature.

MEDICAL EDUCATION COMMITTEE

JAMES M. KOLB, Chairman

The Committee on Medical Education of the Arkansas Medical Society met with Dr. W. C. Langston, Acting Dean of the University of Arkansas School of Medicine, on Thursday, January 26, 1950, at 10:00 a. m. The following members were present: Dr. James M. Kolb, Chairman, of Clarksville; Dr. A. F. Hoge, of Fort Smith; Dr. H. W. Thomas, of Dermott; Dr. G. W. Reagan, of Little Rock; and Dr. C. C. Long, of Ozark. Members absent were: Dr. J. W. Amis, of Fort Smith, and Dr. G. Murphy, Jr., of El Dorado.

After considerable discussion of affairs and problems at the School of Medicine, decision on the following points was reached as outlined:

1. That this Committee recommend to the House of Delegates that they oppose any and all forms of subsidization of medical education which will in any way involve federal control of the medical agency concerned.

2. That this committee recommend to the House of Delegates that they lend all possible efforts to the immediate construction of the new medical center in the securing of adequate funds for the operation.

3. That the membership of the Arkansas Medical Society be requested to use this Committee as a proper channel by which to refer any suggestions, counsel, etc., concerning the School of Medicine.

4. That a copy of all publications, committee appointments, etc., of the Arkansas Medical Society be sent to the Dean of the School of Medicine for his information and record.

5. That the School of Medicine attempt to institute a better system of referral of patients to the University Hospital and the Isaac Folsom Clinic.

6. That this Committee urge the House of Delegates to use every possible means to have Act 346 repealed, which is the law requiring admission to the School of Medicine on a Congressional District basis, for the following reasons:

a. The system is frowned upon by the rating inspectors of the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges as it would cause deterioration of the quality of students.

b. Necessary for the School of Medicine to have the finest quality and talent for medical students.

c. Inferior students later fail, which endangers the medical program and wastes the State's money.

7. That this committee wishes to go on record commending the present administration for the efficient manner in which they are handling the situation.

The following statistics concerning the operation of the School of Medicine and University Hospital were obtained from the authorities of the School of Medicine:

1. Number of applicants, session 1948-1949—232.

2. Number of students accepted in freshman class, session 1948-1949—92.

3. Number of students who failed during session 1948-1949: Freshman year, 11; Sophomore year, 2; Junior year, 1; Senior year, 0; total, 14.

4. Number of graduates, session 1948-1949—54.

5. Number of out-patient visits in 1948-1949—67,279.

6. Number of patients in University Hospital in 1948-1949—6,157.

7. Per diem cost for hospital patients in 1948—$9.61.

8. Number of full-time faculty members in 1948—31; 1949—42.

HEART COMMITTEE

JOHN GREUTTER, Chairman

The advisory committee for the control of heart disease appointed to assist the state health department in its present heart disease control program feels that much has been accomplished. This committee has met on three occasions with representatives of the department of health and plans have been formulated for a well organized program. To date, this much has been accomplished:

1. Approximately $8,000 has been made available from state funds for the purposes of enlargement of the present cardiac clinic, the purchase of needed and necessary equipment, and furnishing clerical and professional assistance in the first established cardio-vascular diagnostic clinic in the University of Arkansas School of Medicine.

2. An educational program with emphasis placed at the professional level is planned. This will consist of statewide visits of certain well known and respected cardiologists from various sections of the United States who will address our medical societies on current concepts of cardio-vascular disease. Lay education will be accomplished through the medium of addresses to civic organizations and the distribution of leaflets and pamphlets.

3. Other heart disease detection centers will be considered at other locations in the state. This facet of the program will be announced at a later date.

As chairman of this committee, I wish to commend the work of each member. Their advice and assistance has been sound, full and complete.

REPORT OF THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY

JOE VERSER, Secretary

The Secretary of the State Medical Board of the Arkansas Medical Society makes the following report of the activity of this board since the last meeting of the Arkansas Medical Society:

The officers of the board are as follows: Charles H. Lutterloh, President, C. Ray Williams, Vice-President, and Joe Verser, Secretary-Treasurer.

At its regular meeting in June, 1949, the members agreed that the board should have its own attorney in order to function more efficiently and to more ably bring to trial those individuals guilty of violation of the Medical Practice Act. The board selected Honorable James Campbell, of Hot Springs, because of his outstanding ability, and, also because of his faithful service to the Arkansas Medical Society in the past. Mr. Campbell attends each meeting of the board and has rendered valuable assistance to the board.

The board also appointed a private investigator, on a fee basis, to make necessary investigation in cases of alleged violations. Recently, however, upon recommendation of our attorney, the board has reported the violation to the attorney general who in turn has called upon the state police to make the necessary investigation. This has proven very satisfactory and less expensive to the board.

A committee from the board, with Mr. Campbell, met with the Legal Affairs Committee from the Society in February of this year to discuss problems of mutual interest to the board and Society. The members of the board feel that this meeting was highly successful and that the Legal Affairs Committee can be of great assistance to the Board of Medical Examiners in the future.

A committee from the board attended the Federation of State Boards meeting in Chicago in February. The committee was instructed while at this meeting to study other state laws regarding the medical practice act in view of writing an ideal medical practice act for this state. After talking to representatives from other states, and listening to their problems, the committee decided that our laws were adequate and that the problems affecting the Arkansas board were far less than the average of other state boards. We do feel that this state is in need of some type of law concerning masseurs and physiotherapists, since so far as we know there are no laws regulating this group. Also, the Society and state board should consider for possible enactment a law recently enacted in Tennessee, which prohibits any individual practicing the healing arts from advertising or soliciting in any form, other than through his regular medical journal. Also, this law requires the individual practitioner, whether he be physician, chiropractor or osteopath, to have his name printed on his office door with his degree and title; such as John Doe, D. C. Chiropractor—rather than Dr. Joe Doe.

The State Medical Board now has reciprocity with Texas and Idaho, making a total of 42 states with which Arkansas reciprocates.

Following is a report of board proceedings—March 1, 1949—March 1, 1950.

Physicians registered for 1950:	
Resident	1,332
Non-resident	391
Physicians licensed by examination	52
Physicians licensed by reciprocity	34
Physicians certified to other states	50
License revoked for non-payment of annual registration fee	110
License suspended for non-payment of annual registration fee	150
License revoked for violation of Federal Narcotic Act	2
Physicians placed on probation for violation of Federal Narcotic Act	2
Court convictions obtained for violation of Medical Practice Act	1
Cases pending for violation of Medical Practice Act	3

Following is a financial report covering the period July 1, 1949, through February 28, 1950. A yearly audit by a Certified Public Accountant will be made June 8, 1950.

Cash on hand—July 1, 1949		$11,178.28
Bonds—Series E, purchase price		6,000.00
Collections from the following:		
Registration fees	$4,298.40	
Reciprocity fees	1,025.00	
Certification fees	405.00	
Primary examination fees	470.00	
Final examination fees	25.00	
Duplicate certificates	5.00	
	$6,228.40	6,228.40
Total		$23,406.68
Expenditures:		
Salary—Secretary & Exp. of board members	$3,493.90	
Attorney fee and travel exp. to meetings	550.00	
Arkansas Medical Society	2,500.00	

Investigator	205.00	
Office rent	105.00	
Dues of Federation of State Boards of U. S.	25.00	
Office expense—Printing, telegrams, postage, freight, stationery, bond, etc.	809.13	
Refunds	65.00	
	$7,753.03	
Total expenditures		7,753.03
Bonds on hand		6,000.00
Cash balance in bank		9,653.65
Total		$23,406.68

ARKANSAS CANCER COMMISSION

C. A. ROSENBAUM, Secretary

The Arkansas Cancer Control Commission will be rounding out its fifth year on June 30, 1950. It was created by Act 277 of the 1945 General Assembly as the official state agency responsible for the cancer control program in Arkansas with these objectives:

1. To establish and conduct permanent tumor clinics for the diagnosis and treatment of indigent cancer patients.

2. To furnish hospitalization for medically indigent cancer patients of the state.

3. To make statistical studies of the cancer problem in Arkansas, reporting recommendations to the state Legislature, the state Board of Health and the Arkansas Medical Society.

4. To participate in a program of cancer education, especially for members of the medical profession in cooperation with other organizations in this field, namely the Arkansas Division, American Cancer Society, and the Arkansas Medical Society.

During its first year, 1945-46, the Cancer Commission served 65 patients. During the fiscal year, 1946-47, 451 patients received Commission services. The next year, 1947-48, 718 patients received Commission aid, and last year, 1948-49, 805 patients were served, making a total of 2,039 patients benefitting the first four years.

Since July 1, 1949, the beginning of our present fiscal year, through March 31, 1950, a period of nine months, 1,102 requests for service have been authorized in the Cancer Commission office, with 808 of this number, new patients in the Commission files.

New Administrative Offices

Rapid growth and expansion of the cancer control program made adequate office space a vital necessity, and on March 15 the central administrative offices of the Cancer Commission were moved to the Rector Building in Little Rock from the State Health Department. Crowded conditions in the State Health Department Building, where our program with full-time personnel began in January, 1947, made it impossible to secure the needed facilities. Our good relationships with that agency are being maintained, and our programs are integrated closely.

Our responsibilities this fiscal year include the administration of the $50,000 appropriated by the State for cancer control, the $60,193 allotted to Arkansas as federal grants-in-aid for cancer control through the United States Public Health Service, and of $16,500 for the Arkansas Division, American Cancer Society, to provide domiciliary care and transportation for indigent cancer patients. Approval by the Cancer Commission, of the Arkansas Division request that the Commission office administer these Cancer Society funds, directs all requests for patient care and service to the Cancer Commission office.

Funds of the Cancer Commission in the amount of $2,500 were made available for the purchase of educational materials for the Arkansas Division, American Cancer Society, at the request of this agency's Executive Board this year.

Seven Commission Designated Tumor Clinics

Each week seven tumor clinics, located strategically throughout the state, meet on schedule to receive indigent cancer patients, referred by the Cancer Commission central office at the request of the patient's doctor for diagnosis and/or treatment. Members of the medical societies in counties where these clinics are located make up the basic and consultant staffs for the tumor clinics.

A monthly summary of clinical activities for the first eight months of this fiscal year, beginning July 1, 1949, reveals an interesting picture in the accompanying table:

TOTAL ACTIVE CANCER CASE LOAD IN COMMISSION DESIGNATED TUMOR CLINICS

For Eight Months, 1949-1950

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.
El Dorado	185	210	231	253	269	274	282	295
Fort Smith	44	84	118	152	173	221	233	243
Jonesboro	106	112	116	120	121	129	134	114
St. Vincent's, Little Rock	96	108	111	116	123	131	137	151
Pine Bluff	153	145	148	153	155	161	165	170
Univ. Hospital, Little Rock	1,219	1,298	1,362	1,366	1,480	1,671	1,671	1,959
Texarkana	187	195	219	222	228	237	254	229
Total	1,990	2,152	2,305	2,382	2,549	2,824	2,876	3,161

Figures available during the last five years reveal that 8,480 patients have been examined in the Commission's designated tumor clinics with 3,353 diagnosed as having cancer, and with 2,781 receiving treatment. These totals do not take into consideration, however, the readmissions at University Hospital tumor clinic for follow-up visits.

State-appropriated funds made available to the Cancer Commission pay a $6.00 per diem for a maximum of 21 days for any one term of hospitalization. Federal funds may be used only for diagnostic hospitalization coming within the first three days and not in the treatment phase. No provision is made by the Cancer Commission for payment of or reimbursement for X-ray therapy. This accounts in part for the large patient load at University Hospital tumor clinic, which is located in Arkansas' only state-supported general hospital. However, X-ray therapy is available without cost to indigent cancer patients at most of the other designated tumor clinics.

In order to give consideration to this important problem, the Cancer Commission has recommended that meetings be called in the various clinical areas, sponsored by the Cancer Control Committee of the Arkansas Medical Society. Jonesboro has been suggested as the first meeting place with all interested citizens and representatives of related agencies and county officials attending.

Central Cancer Registry

For the first time, statistical studies of the cancer problem in Arkansas may be made with information available in the Cancer Commission's Central Cancer Registry. Qualified personnel maintain (1) an alphabetical card system of all patients with a diagnosis of malignant disease, (2) a diagnosis file for the use of physicians interested in research and (3) a follow-up file on patient care. Tumor records and information from the cancer registers of the seven tumor clinics are coordinated in the Central Registry, where detailed tumor records on all patients are filed according to sites. The complete history, physical findings and treatment of a patient will be coded on a single punch card, whereby statistics can be obtained

quickly on machines. The Cancer Commission has completed its code for this purpose.

Many agencies and individuals cooperate with the Central Cancer Registry in securing accurate and complete information for the records. In the follow-up procedure, hundreds of letters have been written to doctors over the state, who have responded wholeheartedly. This was true especially in the breast survey conducted recently on cases seen at University Hospital tumor clinic.

When correspondence with the patient, his family or his doctor is not successful, the Cancer Commission requests assistance of the State Health Department and its public health nurses. Information on cancer deaths is secured through the Bureau of Vital Statistics of the State Health Department. Currently this agency furnishes mortality cancer reports for the Central Cancer Registry. In return for this service the Cancer Commission is providing the Bureau of Vital Statistics with a list of deceased patients for whom death certificates have not been filed.

Radio-Active Materials

In February of this year the Cancer Commission approved the expenditure of an allotted fund for the purchase of radio-active materials to be used in the treatment of cancer patients at University Hospital tumor clinic. So far, two relatively young white males have benefited from radio-active iodine for the treatment of polycythemia vera.

Professional Education

In cooperation with the Committee on Cancer Control of the Arkansas Medical Society, the Cancer Commission sponsored four Cancer Seminars in November, 1949, namely, at Little Rock, Texarkana, Fort Smith and Jonesboro, with staffs of the various tumor clinics, hosts in their clinical areas. Six out-of-state authorities in the fields of survey, X-ray and radium therapy, and research were the speakers. One hundred ninety-six doctors and 37 students at the University of Arkansas School of Medicine participated.

Expenses of cancer speakers at this Arkansas Medical Society meeting are being defrayed with Cancer Commission funds.

All members of the Arkansas Medical Society receive the "Cancer Bulletin," a medical magazine of a new nature, designed to stimulate cancer case-finding. This is being presented by the Cancer Commission and the Committee on Cancer Control of the State Medical Society.

Cancer Commission funds have provided refresher courses this fiscal year for one radiologist and one surgeon, who serve on a tumor clinic staff.

It is urged strongly that all county medical societies devote at least one meeting each year to cancer control and that all members see the professional films, now available: "Cancer: The Problem of Early Diagnosis," and "Breast Cancer: The Problem of Early Diagnosis." This summer the National Cancer Institute, in cooperation with the American Cancer Society, is to release a film on breast self examination for lay women audiences. It is anticipated that greater demands upon the services of the medical profession will result.

In October the Commission's acting director and administrative assistant represented this agency at the American Public Health Association held at New York.

Association of Tumor Clinic Staff Members in Arkansas

This association, which was organized in March, 1949, in Little Rock, held its second session in January at Texarkana with members of the various tumor clinic staffs taking part in three panel discussions, namely: Cancer of the Breast, Cancer of the Cervix, and Skin Cancer. The next association meeting is planned for May 20 in Fort Smith with the newly elected chairman, Dr. D. W. Goldstein, taking office.

Program Review

Evaluation of the cancer control program in Arkansas for the past fiscal year, July 1, 1947, through June 30, 1948, by consultants from the United States Public Health Service rated the efficiency of the Commission program "well above the average." The review "noted that the Commission has done a commendable job in a short period of time."

This evaluation is gratifying indeed to those who have been vitally interested in establishing a good program for cancer control in Arkansas. And it is a real tribute to the medical profession of the state, the doctors, who have contributed their skill and time in this fight to solve the riddle of cancer.

DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

R. B. ROBINS, Delegate

Important actions taken at the June meeting of the American Medical Association House of Delegates were:

1. Action Concerning Hospitals and the Practice of Medicine. It was decided that the Judicial Council of the AMA had the power to find a hospital or lay group guilty of violating the Principles of Ethics and recommended that the Judicial Council order the withdrawal of the Association's support and approval of a hospital which did not comply.

2. On Prepayment Medical Care. The American Medical Association is not engaged in the insurance business and has no intention of giving a preferential standing to any one type of voluntary plan. The Association does, however, evaluate insurance plans with a view to protecting people against unscrupulous and unsound plans.

The Council on Medical Service recommended the formation of a national coordinating agency to represent all qualified voluntary prepayment plans. The Council recommended that there should be no official connection between the American Medical Association and the Associated Medical Care Plans, but that Associated Medical Care Plans should be recognized as a trade organization of member plans and the Blue Cross as a similar trade organization for the voluntary hospital care plans.

The Council feels that the function of the American Medical Association is to promote the principle of voluntary insurance by education and to inform the American people of the availability of approved plans.

3. Action on Classification of Medical Schools. Approval of a consideration and classification of foreign medical schools with a view to aiding state licensing boards in establishing their policies with respect to licensure of foreign graduates was granted by the House of Delegates to the Council on Medical Education and Hospitals.

The House of Delegates also approved action leading to the following procedures: (1) Graduate and postgraduate education for general practitioners should be more widely available; (2) two-year rotating internships should be especially designed for those who wish to train for general practice, and (3) the American Medical Association should most urgently insist that hospitals make freely available to qualified general practitioners all their facilities for the care of the sick.

4. General Practitioner's Award. A resolution was introduced suggesting the abandonment of the annual award of a medal to a leading general practitioner. The House of Delegates, however, decided to continue this award.

These and other actions of the House of Delegates at the Atlantic City meeting of the American Medical Association have been published already in the various journals and, I am sure, need no further amplification in this report.

I would like to close my report by thanking you for giving me the honor of serving as one of your delegates to the American Medical Association. It has been a pleasure to serve the medical profession of my state and my country.

INTERIM SESSION OF THE AMERICAN MEDICAL ASSOCIATION

JOE F. SHUFFIELD, Alternate

Dr. R. B. Robins and myself were your delegates to the American Medical Association Interim Session in Washington, D. C., in December, 1949. The House of Delegates of the American Medical Association is a very interesting body. It acts very rapidly and with precision. The delegates go there well prepared on the various subjects to be discussed and they are very definite in their thoughts and are not reluctant in expressing what they think.

The following actions of the House of Delegates of the AMA we wish to call to your attention:

1. Established dues in the AMA for the first time. The dues are $25.00 per year for every physician who is in active practice.

2. Suggested that the AMA officers be compensated more fully for their expenses while in office.

3. Reaffirmed the need for fighting hospital encroachment on the practice of medicine.

4. Passed a resolution calling for national organization of interns and medical students to be set up under AMA auspices. To have space in AMA Journal. "Junior AMA." Directed Trustees to present suitable plans for such an organization at the next AMA session.

5. Passed a resolution asking state societies to set up "Grievance Committees."

6. Passed a resolution asking for better pay for local public health officers throughout the country.

7. Applauded life insurance companies that have voluntarily increased fees paid for medical examinations.

8. Requested more rural communities to help young physicians to get started by staking them to offices and equipment.

9. Authorized a committee of laymen to assist in the AMA's national educational campaign.

10. Named 84-year-old Dr. Andy Hall of Mt. Vernon, Illinois, the outstanding general practitioner of the year. There were 37 entries and Dr. T. E. Rhine of Arkansas ran second in the voting on the selection of the general practitioner of the year. This was a signal honor for the Arkansas Medical Society, and for Dr. Rhine. Arkansas had a wonderful good-will party December 5th in the Grand Ballroom of the Mayflower Hotel and entertained about 400 guests which included nearly all of the delegates to the AMA. This was to make the Arkansas Medical Society better known and to get the members of the House of Delegates to meet Dr. Rhine. In the receiving line were Dr. T. E. Rhine and family and nearly all of the important people from Arkansas now in Washington. Frances Greer, Metropolitan Opera star, sang. She is a native of Helena, Arkansas. Arkansas Razorback souvenirs furnished by the Camden Pottery Company were given away. The Grapette Company of Camden furnished the punch that was served. Also, many delicate foods were served. There was very little speaking done at this good-will party. We feel that this party did much good.

The next Interim Session will be in Denver, Colorado, November 28 to December 1, 1950.

REPORT OF THE COUNCIL

JOHN H. WILSON, Chairman

The Council met on July 10, 1949. The action taken and the recommendations made are herewith submitted to the House of Delegates, and are as follows:

1. Appointed Councilor Hundley as Society representative to attend the conference of the AMA Bureau of School Health in Highland Park, Illinois, during October.

2. Approved the giving of a special Society party at the Interim Session in Washington, D. C., on December 5, 1949, in honor of Dr. T. E. Rhine, Arkansas' candidate for the "General Practitioner of the Year," the arrangements committee for which was comprised of R. B. Robins, chairman; W. R. Brooksher and Euclid M. Smith.

3. Authorized the sum of $350 to the Woman's Auxiliary for conducting an essay contest among Arkansas school children during the fall term of 1949.

4. Approved the conducting of a survey of present Councilor Districts with the view of rearranging the Eighth Councilor District and appointed a committee of Louis K. Hundley, chairman; Fount Richardson and E. H. Wilkes to conduct the survey.

The Council met on October 5, 1949, and took the following action:

1. Approved plans for a state-wide meeting among members in February, 1950, for the discussion of aspects of compulsory health insurance and pending national legislation tending along such lines.

2. Recommended that nominations of three members from the Third Congressional District to fill the vacancy occurring on the state medical board be made by delegates of county medical societies in that Congressional District.

3. Recommended that county medical societies in all councilor districts hold special meetings with congressmen from the respective congressional districts to discuss pending national legislation affecting the medical profession.

The Council met on December 29, 1949, and took the following action:

1. Approved the action taken by the House of Delegates of the American Medical Association at the Interim Session to assess membership dues of $25.00 in 1950.

2. Authorized the formation of a Society grievance committee to be composed of one member from each of the ten councilor districts.

3. Reaffirmed opposition to S. 1411, S. 1453 and H. R. 6000—each, in its entirety.

4. Authorized an increase in Journal professional card rates to $15.00 and $25.00, respectively, beginning January 1, 1950, with a special $2.50 charge for revising professional card copy.

5. Approved the sending of a special request by the Secretary to Governor McMath that a physician member be appointed to the University of Arkansas Board of Trustees after effective resignation date of Euclid M. Smith.

The Council met on January 15, 1950, and took the following action:

1. Adopted resolutions passed at the January 8th Denver Conference opposing S. 1453 (H. R. 5940), S. 1411 and H. R. 6000 in their entirety and ordered mimeographed copies sent to the Arkansas delegation.

2. Approved the proposed advertising campaign of the American Medical Association with the provision that

all advertising handled by a national agency be channeled through state press associations, rather than by direct placement of advertising by a national agency.

3. Authorized Chairman Reid of the Rural Health Committee to attend the AMA Rural Health Conference at Kansas City in February as Society delegate.

4. Authorized Charles Henry, George Steinkamp and Mr. Sid Wrightsman, Jr., as Society delegates to attend the Whitaker & Baxter Conference in Chicago on February 12, 1950.

5. Designated itself as a state legislative committee to cooperate with the recently-appointed AMA Legislative Coordinating Committee.

The Council met on January 22, 1950, and took the following action:

1. Authorized the formation of a Council Executive Committee (composed of the Society President, President-Elect, Secretary and Council Chairman) to act for the Council as a whole on occasion when pending national legislation would require immediate action by the Society and to serve until the 1950 Annual Session.

2. Authorized sending fraternal delegates to Arlington County (Va.) Medical Society meetings on invitation.

The Council met at the Goldman Hotel in Fort Smith on the night of Sunday, April 16, and the following action was taken:

1. Approved Life Member applications from: E. C. Hunt, Ola, Pope-Yell County; S. M. Graves, Clarksville, Johnson County; W. B. Gould, Glenwood, Howard-Pike County; W. H. Toland, Nashville, Howard-Pike County.

2. Approved Affiliate Member application from C. N. Bogart, Forrest City, Cross-St. Francis County.

And recommended their acceptance by the House of Delegates.

3. Recommended to the House of Delegates that County Societies be impressed with the importance of and remit immediately 1950 American Medical Association membership dues for every member and recommended to the House of Delegates that Article XI of the Constitution be amended to read by adding the following at the end of the second sentence: . . . "Provided, that membership in this Society shall be restricted to those who possess the qualifications set forth in Article IV and who pay the annual dues of the American Medical Association in addition to dues to their component and state society" . . . This amendment to be drawn up by the Council Committee of Doctors Dickinson, Allbright and McDaniel.

4. Recommended that resolution be submitted to the House of Delegates to amend Article VI of the Constitution to include one Vice-Councilor from each medical district and appointed committee of Doctors Dickinson, Gay and Richardson to draw up the resolution.

5. Recommended the appointment of a Council committee composed of Doctors Dickinson, Gay and Richardson to consult with the Advisory Committee of the Arkansas Hospital Association in regard to recent complaints about the Hospital Division of the Arkansas State Board of Health.

6. Accepted report on reorganization of councilor districts composing the Arkansas Medical Society as submitted by the special committee, and recommended its adoption by the House of Delegates.

7. Nominated Carl Rosenbaum and W. G. Cooper of Little Rock for appointment by Governor to Arkansas Cancer Commission.

8. Recommended that the following resolution be passed by the House of Delegates of the Arkansas Medical Society: "In its constant effort to improve the health of our nation the American Medical Association has appointed our fellow-citizen, Aubrey D. Gates, as Field Director for Rural Health. Therefore, be it resolved that we heartily approve this selection, and pledge our hearty assistance in furtherance of the task in which he is engaged."

9. Recommended that the House of Delegates pass a resolution endorsing a national survey on physicians' incomes, to be undertaken jointly by the American Medical Association and the United States Chamber of Commerce, as published in the current issue of the Journal of the American Medical Association.

The Council met at the Goldman Hotel in Fort Smith on Monday, April 17, with the following action undertaken:

1. Appointed committee of three to investigate the feasibility of combining the offices of the state examining board, the basic science board and the headquarters office of the Arkansas Medical Society in Little Rock.

2. Recommended that House of Delegates instruct the Committee on Medical Education to investigate the proposed Medical Center of the University of Arkansas School of Medicine with respect to the method of financing the plan of operation and its relation to medical practice of Arkansas.

3. Reaffirmed its opposition to federalization of medicine, federal subsidization of medical education, of power, of housing, and to socialization in general and recommended that the House of Delegates unanimously adopt the following resolution:

"Whereas, the Arkansas Medical Society at its last annual session passed resolutions opposing socialized medicine legilation; and

"Whereas, the Arkansas Medical Society strongly endorses the National Educational Campaign of the American Medical Association against socialized medicine legislation and compulsory federal health insurance; now, therefore,

"Be it resolved, that the Arkansas Medical Society in annual session at Fort Smith, Arkansas, April 17-19, 1950, reaffirms its opposition to any form of compulsory federal health insurance or any system of political medicine designed for national bureaucratic control and to federal subsidy of housing, utilities, medical education and to socialization in general, and endorses the National Educational Campaign of the American Medical Association;

"Be it further resolved, that a copy of this resolution be forwarded to the President of the United States, to the two Senators and the seven Congressmen from Arkansas and to the American Medical Association."

REPORT OF LEGAL COUNSEL

MR. EUGENE R. WARREN, Attorney-at-Law

Your attorney submits herewith a brief report of legal services furnished during the year 1949.

Generally, the Society has had available to it at all times the services of not only the general counsel, but of Mr. Bruce T. Bullion, Mr. N. Walls Trimble and Mr. R. Eugene Bailey, associates, who are well-qualified, experienced attorneys. The entire staff has held itself ready to provide whatever services the Society has requested.

Legislation

The 1949 Legislative session passed no laws which adversely affected the Society. There were numerous bills introduced which were thought to be detrimental to the best interest of the Society and of the public, but these measures were defeated in the Legislature. There were other measures which were introduced in the session

which were thought to be for the public good and in the public interest, and passage of these acts was urged by us. Your counsel's participation in efforts to advise the various members of the General Assembly as to the merits of legislation was only after conference with and advice of representatives of the Society.

It is thought not necessary to list the various measures of which consideration was given, in the interest of brevity and in view of the fact that the list would have but historical value.

Of particular importance was a resolution which we prepared and submitted to the General Assembly memorializing the Congress of the United States not to federalize the practice of medicine. We are happy to report that without opposition this resolution was adopted by both branches of the General Assembly and copies furnished the President of the United States, the presiding officer of each branch of the Congress and to each senator and congressman from Arkansas.

Legal Opinions

Your counsel has furnished, at various times when called upon, legal opinions on questions presenting themselves through appropriate channels. We were instructed to furnish opinions only when requested to do so by the office of the Secretary, through which all requests for legal opinions must clear. The legal problems presenting themselves were many and varied, and copies of the opinions are on file in the office of the Executive Secretary. This report will not attempt to review the various legal questions presented for opinion, but the brief reference made is considered sufficient.

The Collateral Activities

Among the collateral activities engaged in by counsel for the Society, of interest to the Society, were numerous appearances at which talks were given explaining the evils of socialized medicine. Your counsel appeared upon several radio forums or town meetings to debate questions presented by national health insurance. Invitations to speak against the socialized trend were received from various parts of the state, and speeches delivered whenever the opportunity presented itself.

Of particular interest was the debate held in Pine Bluff at which the FSA furnished speakers to debate Dr. Hunter Causey and your counsel. We were particularly impressed by the lack of substantial reason advanced by the representatives of the FSA substantiating their views. Appeal was made upon an emotional basis without foundation of fact, and upon personal opinions of the speakers. Since this meeting we have had no opportunity to answer any further representatives of the FSA, although we hope in the future to have the privilege of a joint discussion of the questions.

We are pleased to report that wherever the national health insurance proposal has been discussed with the citizens of our state, and a full explanation made of the terms of the proposal, the reaction has been unanimous in opposition.

Recommendations

Your counsel recommends:

1. That studies be made several months prior to the next legislative session of legislation thought to be beneficial to the public and to the profession;

2. That studies be made to determine the advisability of preparation of a modern medical practice act;

3. That the opposition to the principle of socialized medicine be continued without letup;

4. That the practice of submitting requests for legal opinions only through the Secretary's office be continued.

REPORT OF THE TREASURER

PAUL L. MAHONEY, Treasurer

Balance, April 1, 1949:		
Treasury Bonds	$11,400.00	
Loan to Arkansas Med. & Hosp. Services	10,000.00	
Bank Account	9,372.04	
	$30,772.04	$30,772.04
Receipts:		
From Secretary	$35,500.00	
Interest—Treasury Bonds	285.00	
Employees' Taxes Withheld	11.15	
	$35,796.15	35,796.15
		$66,573.39
Disbursements		35,733.13
Balance, March 31, 1950:		
Treasury Bonds	$11,400.00	
Loan to Arkansas Med. & Hosp. Service	10,000.00	
Balance in Commercial National Bank, Little Rock, Arkansas	9,440.26	
		$30,840.26
In hands of Secretary for transfer to Treasurer		7,298.74
TOTAL BALANCE, MARCH 31, 1950		$38,139.00

REPORT OF THE EXECUTIVE SECRETARY

MR. SID WRIGHTSMAN, JR.

Because of the National Administration's increased effort to pass legislation tending to be along lines of compulsory health measures, combined with a growing public interest in stemming welfare statism—an interest enhanced by publication of the Hoover Commission Report early last year—the executive secretary throughout 1949 devoted considerable time to keeping Society members informed on legislative trends affecting them, both as citizens and physicians.

This, in the main, was accomplished by the frequent issuing of special news bulletins on the advice of Dr. W. R. Brooksher, Secretary, and Dr. Charles R. Henry, Chairman of the Committee for the Extension of Medical Care.

To carry on the education campaign in the state as envisioned by the Committee for the Extension of Medical Care, the Council, early in 1949, authorized the employment by the executive secretary of a full-time stenographic assistant and approved purchase of suitable mimeograph equipment, an addressing machine and other necessary office paraphernalia for his office.

In addition, his office cooperated in furthering state campaign activities by (1) serving as the major point of distribution of campaign material furnished by Whitaker & Baxter, public relations counsel for the American Medical Association and (2) state collection agency for the 1949 AMA voluntary assessment on members and (3) cooperating with officers of the Woman's Auxiliary in their various activities requiring the distribution of mimeographed material to the Auxiliary membership.

On December 31, 1949, the Society had a total of 1,220 members in-good-standing, having remitted 1949 State dues.

In the collection of the 1949 AMA voluntary assessments, this Society stood twentieth on the list of fifty-three constituent associations comprising the American Medical Association. The sum collected represented payment of

the assessment by approximately 73 per cent of the Society membership.

The executive secretary is convinced that experiences learned during the past year will prove invaluable to him in his work for the Society during 1950, an election year which, even now, has every indication of being a decisive period in the Administration's campaign for compulsory health measures.

For their continuous cooperation and innumerable courtesies shown him throughout 1949, the executive secretary expresses profound gratitude both to officers and members of the Arkansas Medical Society.

R. B. Robins addressed the House of Delegates on the importance of American physicians assuming their duties as citizens, especially during the election year of 1950, when major decisions will be a necessity involving the American way of life as opposed to socialistic trends in the government.

Louis K. Hundley outlined the proposed reorganization of Councilor Districts to be affected as follows: First District—Clay, Craighead-Poinsett, Crittenden, Fulton, Greene, Lawrence, Mississippi, Randolph and Sharp Counties; Second District—Cleburne, Conway, Faulkner, Independence, Izard, Jackson, Stone and White Counties; Third District—Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis and Woodruff Counties; Fourth District—Ashley, Chicot, Desha, Drew, Jefferson and Lincoln Counties; Fifth District—Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita and Union Counties; Sixth District—Hempstead, Howard-Pike, Lafayette, Little River, Miller, Nevada, Polk and Sevier Counties; Seventh District—Clark, Garland, Grant, Hot Spring, Montgomery and Saline Counties; Eighth District—Pulaski County; Ninth District—Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren and Washington Counties; Tenth District—Crawford, Franklin, Johnson, Logan, Pope-Yell, Scott and Sebastian Counties.

By motion (Hunt-Rush) the district reorganization plan was adopted to become effective at the 1951 Annual Session.

John W. Smith read the following resolution which was referred to the Reference Committee:

WHEREAS, the public looks to the medical profession for leadership in matters involving the health of the people of the State, and

WHEREAS, the medical profession in general has long recognized the need of proper child spacing in selected cases, and

WHEREAS, the American Medical Association has endorsed the rendering by the medical profession, of information and advice concerning the prevention of conception; therefore

BE IT RESOLVED: That the Arkansas Medical Society go on record as favoring the introduction of birth control for the indigent, and medically determined cases as a public health activity of the Arkansas State Board of Health.

Secretary Brooksher explained the necessary nominations to the Arkansas State Board of Health to be made in the Second and Fourth Congressional Districts with the expiration of terms of E. D. McKnight, Brinkley (Second District) and C. A. Archer, De Queen (Fourth District) effective after December 31, 1950.

The House then proceeded to select the following Nominating Committee: First District, L. H. McDaniel; Second District, S. J. Allbright; Third District, J. O. Rush; Fourth District, H. T. Smith; Fifth District, H. J. Mayfield; Sixth District, M. L. Norwood; Seventh District, J. W. Kennedy; Eighth District, Daniel Autry; Ninth District, J. G. Gladden, and Tenth District, James Kolb.

Nominations to the Arkansas State Board of Health were announced to be E. D. McKnight, K. K. Kimberlin and L. T. Evans of the Second Congressional District, and C. A. Archer, D. W. Goldstein and Fred F. Ferguson of the Fourth Congressional District.

The House then adjourned.

Monday Night, April 17, 1950

Sponsored by members of the Sebastian County Medical Society, a series of Open Houses was held throughout Fort Smith by the following: Cooper Clinic, Holt-Krock Clinic, Dr. and Mrs. A. S. Koenig and Dr. and Mrs. Thomas P. Foltz.

THIRD GENERAL SESSION

Tuesday, April 18, 1950 — 9:30 A. M.

The meeting was called to order by President Smith, and Vice-President L. T. Evans took the chair.

The following scientific program was presented:

"Infectious Mononucleosis," G. H. Butler, Fayetteville.

"Urological Problems in Children," Barney P. Briggs and James Headstream, Little Rock.

"The Dysenteries," Frank M. Acree, Greenville, Mississippi.

"State Hospital Problems in the Mid-West," E. Rogers Smith, Indianapolis.

"What the University of Arkansas Department of Pathology Means to the General Practitioner," Anderson Nettleship, Little Rock.

MEMORIAL SESSION

April 18, 1950

The meeting was called to order by President Smith at 11:40 A. M.

The invocation was given by Rev. Wallace R.

Bacon, First Christian Church, Fort Smith.

A musical selection, "There Is No Death" (O'Hara), was given by Mr. Bob McDaniel, accompanied by Miss Lola Watson.

Mrs. Louis K. Hundley read the names of deceased members of the Auxiliary.

Mr. Sid Wrightsman, Jr., read the names of the following deceased members:

IN MEMORIAM

Rufus Martin, Warren, April 15, 1949.
Alfred Frederic Gray, Little Rock, April 22, 1949.
John M. McLean, Caddo Gap, April 27, 1949.
J. R. Crigler, Alma, May 7, 1949.
Braxton V. Powell, Camden, May 12, 1949.
Homer Dickens, DeWitt, June 6, 1949.
William C. Russwurm, Helena, June 9, 1949.
Edward O. Day, Little Rock, July 18, 1949.
Rube C. Kennerly, Camden, July 29, 1949.
William F. Rogers, St. Joe, August 5, 1949.
Charles C. Anderson, Little Rock, August 16, 1949.
William H. Poynor, Harrison, September 12, 1949.
William C. Porter, Ozark, September 13, 1949.
Isaac Grady Jones, DeQueen, September 18, 1949.
David Carson Roberts, Berryville, October 2, 1949.
Cleo C. Ball, Ravenden, November 4, 1949.
Felix E. Baker, Stamps, November 20, 1949.
John Short Jenkins, Pine Bluff, December 1, 1949.
Oran D. Ward, England, December 12, 1949.
Walter W. Brown, Hardy, December 13, 1949.
John James Morrow, Mountain Home, December 13, 1949.
John E. Cunning, Little Rock, December 16, 1949.
Donald Wayne Dykstra, Little Rock, December 31, 1949.
Jesse S. Rhinehart, Camden, January 8, 1950.
Edward Pelham McGehee, Lake Village, January 9, 1950.
Oscar Aden Jamison, Tuckerman, January 27, 1950.
T. E. Fuller, Texarkana, February 1, 1950.
A. G. Emerson, Balk Knob, February 2, 1950.
E. L. Thompson, Hot Springs, February 14, 1950.
J. B. Ivy, Tuckerman, March 30, 1950.

L. H. McDaniel, Tyronza, gave the Memorial Address.

Should you go first and I remain
To walk the road alone,
I'll live in memory's garden, Doctor friend,
With happy days we've known,
In Spring I'll watch for roses red,
When fades the lilac blue,
In early Fall when brown leaves call
I'll catch a glimpse of you.

Should you go first and I remain
For battles to be fought,
Each thing you've touched along the way
Will be a hallowed spot.
I'll hear your voice, I'll see your smile,
Though blindly I may grope,
The memory of your helping hand
Will buoy me on with hope.

Should you go first and I remain
To finish with the scroll,
No length'ning shadows shall creep in
To make this life seem droll.
We've known so much of happiness,
We've had our cup of joy,
And memory is one gift of God
That death cannot destroy.

Should you go first and I remain,
One thing I'd have you do:
Walk slowly down that long, lone path,
For soon I'll follow you.
I'll want to know each step you take
That I may walk the same,
For some day down that lonely road
You'll hear me call—your name, Doctor friend.

From the Castle Rock which dominates the city of Edinburgh, four buglers blow "the last post" at the sunset of every day. As you know, "the last post" in the British Army is equivalent to our taps. There is a tradition that in ancient times it was customary for five buglers to blow "the last post." But on a March-end long ago one of the buglers was murdered, and since that day the buglers have been limited to four. And there is a sort of half-belief among Edinburghers that on every March 31st, when the last notes of the four buglers have died away, listeners in quiet places, if their hearts are quiet, and their minds are receptive, can hear the faint, far-off notes of the fifth bugler sounding as of old. This, of course, is a tender fancy, but it illustrates a noble truth, namely, that from the Castle Rock of our profession there are vanished buglers calling. Ah! my friends, as I listen I fancy that I hear each of those "vanished buglers" we honor today in this Memorial Service, sounding the clarion call—distant, yes, but still so distinct—for us to carry on the fight against human disease and human misery. Ah! my friends, that distant note I fancy that I hear resounding from afar does come from each of those great souls we honor today, that group of men who answered the call of duty to palace and hovel alike, that group of men who heard secrets and confessions not breathed to other mortals, that group of men who were so often called upon to whisper consolation to some poor suffering soul on the brink of this earthly silence, that group of men who were trusted with everything mortal that this life affords, that group of men who labored through love under a system we know as Medical Ethics, the ideals of which are not surpassed by any organization, religious or otherwise, that system which in its ultimate analysis is but a continuation of the Sermon on the Mount by the Great Physician, that One who ever directs the internist's diagnosis or the surgeon's hand.

We have instituted this memorial service as part of our medical meeting in order that we may hear more clearly our own vanished buglers calling.

In that book which we all revere but read too little, an unknown writer calls the roll of the faithful and tells of their useful deeds. Then he closes with the astounding statement that without us their works cannot be perfect. In 1842 Abraham Lincoln gave an address on George Washington in which he said, "To add brightness to the sun or glory to the name of Washington is alike impossible. Let none attempt it. In solemn awe pronounce his name and in its naked, deathless splendor, leave it shining on." That is beautiful rhetoric but in the highest, noblest sense it is incorrect. If, as we say, Washington is the father of this country, and if the glory of the father is enhanced by the accomplishments of his children, then we can add glory to Washington's name and greatness to his fame. Likewise we can add to the name and fame of our fellow-physicians who have laid down their instruments and gone on the long exodus of death. As the architect lives on in the growing splendor of the cathedral he designed but never saw completed, so our fellow-physicians who have departed can live on and come to nobler completion in us. For we are co-workers with those who have gone before, just as the later workmen

on a cathedral are co-workers with those who laid its foundations and began the building of its walls years before. The separations which are made by calendars do not affect the unity of our service.

All society and all societies are compacts of the living, the dead, and the unborn. Wordsworth declared: "There is one great society, the noble living and the noble dead." Our conception of our medical society is not high enough if we leave out that part of it which has gone beyond our physical sight. When a doctor has practiced medicine in one locality for 30 years, most of the medical society, as that doctor first knew it, is behind the veil:

For behind the veil go more faces every year;
And loved ones leave vacant places every year;
If we look aright their souls can meet us
In carrying on their spirits greet us
To remember them they entreat us, every year.

That unknown New Testament writer of whom I have already referred, saw the departed as a great cloud of witnesses looking down from the balcony of heaven and cheering as we run our race. He said that because we are surrounded by such a great cloud of witnesses we ought to lay aside the things that hinder us and run a good race. Though they are dead, says this writer of the Letter to the Hebrews, they are still speaking to us. The elder William Pitt used to take his son William on an every Saturday tour of the ancestral portraits which adorned the walls of the great ancestral mansion. Pausing before each portrait he would say: "Son, that is grandfather," or "that is your great grandfather." And then he would add: "Son, you must hear what these men and women are saying to you." Likewise we must hear what our departed fellow-physicians are saying to us. They are reminding us that we have a great debt to discharge because we are debtors to all the ages. They are reminding us that we are stewards of a noble heritage and that it is required of stewards that a man be found faithful.

Instinctive faith joined with reason has led the ages to believe that the span of existence which fades from our mortal eyes into the mist of the unknown is an arch which in God's good time and in keeping with His own divine wisdom will be completed to another and better shore. To follow out the symbol of our bridge of faith we might say that John found two piers supporting the bridge to immortality. First, the love of God. We are God's sons and daughters. Therefore, we may rest assured that the deep longing for immortality which he has placed in our hearts is an index to reality. I had a human father. He loved me dearly. There is nothing he would not have done for my benefit. God's love for us is even greater than that. The second pier, of course, is Jesus who said: "I am the resurrection and the life; whosoever liveth and believeth in me shall never die."

The second intimation is that to all of us, life as we know it here is unfinished. In the realm of music Franz Shubert is considered a genius of tone poetry, yet his work is characterized by loose ends. He left many manuscripts incomplete. One of his works which is considered perhaps the best of all is called "The Unfinished Symphony." Two movements are complete and beautifully polished, one page of the third likewise; then the production breaks off into ragged ends. Some of the greatest paintings were left by their creators incomplete. "The Last Supper," which ranks perhaps highest of all in popular esteem, was left by the artist with all complete in detail except the face of Jesus. An artist of lesser genius and of less sensitive conscience filled in the unfinished face. The Madonnas of Raphael have been objects of wonder and admiration through the ages, but when Raphael was dying at the age of thirty-seven he said the most beautiful Madonna was still in his heart, unpainted.

This is a picture of life as it is—as it doubtless was—to that group of departed brothers we honor today; always unfinished. Life's symphonies are always unfinished, because life here is so often not big nor long enough. Dreams of youth, noble aspirations and high endeavors always over-leap the possibilities of life in this world, even at its best.

What then are we to say about life? Are we to shrug our shoulders and say: "Well, life is just like that." Or is there a deeper and more intelligent meaning? For tokens of immortality are written into the very fabric of life as we live it. Life swings outward and upward across the deep promising achievements which are eternal and almost divine. As far as this life is concerned the story frequently and suddenly breaks off with disappointing incompleteness. It often does. But if our eyes are clear, we may see the rising piers coming out from another shore to meet life's unbroken span. And if we have faith in the great Architect we know that the arch will be completed in accordance with his own good pleasure and all will be well.

Again we know that these whom we remember today though dead are alive forevermore, because we have known and loved them. We can still feel the touch of their hands, we can still hear the sound of their voice, we can still feel their influence and see their form in the places where they have been. Not perhaps with the physical sight but with the inner sight of our heart. There their memory and influence will remain forevermore indelibly imprinted not on paper or stone but upon the hearts of flesh that loved and were loved by them.

What medicine is in the State of Arkansas today, doctors who have gone before us have helped to make it. There is a very true sense in which every generation is the residuary of the past. We live most worthily in our own generation if gratefully and respectfully we look in retrospect to those who have gone before. There is much sanguine realism in the statements credited to the Nazarene who was the Great Physician when He said: "Other men have labored, ye have entered into their labors." In proportion as we appreciate the contributions of the past do we become worthy custodians of this heritage and active agents toward a better future today.

In seeking for a single word which is the embodiment of the spirit of a true doctor, perhaps there is none more fitting than the word selflessness, a much stronger word than unselfishness. Surely it is true that the life of a doctor is a demanding life when the welfare of others is so desperately at stake. Of necessity self must be forgotten when the race with disease and death is involved. Few professions, if any, lend themselves to the life of unselfish service as does medicine. Yet constantly we, like men of other professions, must be on guard lest we allow a lower level of professional conception to dominate us.

At this moment I am recalling an interesting bit of Rumanian history. When Carmen Sylva was Queen of Rumania she paid a chance visit to the workshop of the noted English artist, Frederick W. Watts. Having passed the friendly pleasantries of the day she said to this artist: "Do you remember the words of the German writer who, in trying to define the meaning of life, said: 'What I spent I had, what I saved I lost, what I gave I have'?" His imagination being quickened by these words, he said: "Won't you speak those lines again?" She did, and immediately the creative genius of the artist began working in an effort to conceive some way in which, on canvas,

these meaningful abstractions could be objectified. The outcome of his study was a masterpiece which continues to this day to rank high among the vital conceptions in the world of art.

First, he drew back a dark curtain, on one side of which in gold letters he wrote, "What I spent I had"; at the center, "What I saved, I lost"; and at the other side, "What I gave, I have." Directly in front of this he drew a bier 6½ feet long, 2½ feet wide, and on it, placed the body of a man and covered it with a gray shroud. The body of the man was rigid. His head was thrown back, his chin lifted, exhibiting an attitude of utter defiance and dissatisfaction, depicting an unsatisfied heart midway of life because that life had not yielded to him the thing which most the inner nature craves, satisfaction and peace. On the floor directly in front of the table, the artist indicated the objects suggestive of the pursuits which he had followed. Here was the ink well, the pen and the parchment, suggesting a career of letters. Over there was the shield and the spear and the sword, indicating his interest in war. Here was the ermine mantle suggestive of his social standing and wealth. Over there was the chaplet of leaves indicating that he had been in some contest a victor. All of these things, each perhaps worthy in itself, had failed to give to him the thing which most he desired. Perhaps the explanation lies in the fact that he had pursued his objectives with selfish ends only in view, allowing his life to be too largely dominated by the first inscription, "What I spent I had." How easy it is for us all to fall under the delusion that life in its fullness can be realized through a profligate spending of self or substance. How subject we all are to the seductions of the biological in us which would interpret life in terms of emotional spasms or passing pleasure. Was it not Burns who said, speaking out of wealth of tragic experience: "Pleasures are like poppies spread, you seize the flower, its bloom is shed; or like the snowflake on the river—a moment white, then gone forever."

It may be that this man had allowed this second statement too largely to dominate him: "What I saved, I lost." How easy it is for one to allow the acquiring instinct to control his life and conceive of satisfaction only terms of income rather than outgo. How quickly one becomes subject to the mandates of the material if he allows uncontrolled sway of his life by the instinct to get, without at the same time providing altruistic outlets through which life surges out on kindly errands. No, we may never expect life's truest riches to arise from such philosophy.

The lives and work of our fraternal dead, whom today we memorialize, have worthily escaped the pernicious influence of these two persuasions and they have gladly given themselves to be controlled by the third of these principles: "What I gave, I have." Isn't it a strange kind of mathematics which allows such a statement as that to be true? Yet, it is true. However, it is more than mathematics. It is the principle which reaches down into the very interior of life, sustaining relationship with man's worthiest estates and kinship with the very nature of God. Life's deepest satisfactions are never derived by a profligate spending of self or substance; or by the withholding of life's emoluments from a gracious and sympathetic sharing with others. Only as we come to share the spirit of the "Great Physician," the Nazarene, who went about doing good—as did Pasteur, Banting, Frank Vinsonhaler, and a host of others—can we expect to nourish those satisfactions that sustain the soul. "Who gives himself with his alms feeds three, himself, his hungrying neighbor and Me. Not what we give but what we share, for the gift without the giver is bare." This Memorial Service is separated from Passion Week and the day commemorative of the resurrection of Christ by only a short span of a few days, involving recognition by the whole of Christendom of Him who gave Himself wholly that He might make man free and well. The reason why we today are able to stand in honorable commemoration of our departed friends—those "vanished buglers," if you please—because their ministry to mankind had in it the spirit of sharing and giving and serving. To the highest degree we may honor them not in words of tribute but in deeds of action which in us who remain shall give manifest evidence of this abiding principle in our individual lives from day to day.

"THY WILL BE DONE"

We see not, know not; all our way
Is night; with Thee along is day.
From out the torrent's troubled drift,
Above the storms we lift,
Thy will be done.
The flesh may fail, the heart may faint;
But who are we to make complaint,
Or dare to plead in times like these,
The weakness of our love or ease,
Thy will be done.
We take with solemn thankfulness
Our burdens up, nor ask it less;
And count it joy that even we
May suffer, serve, or wait for Thee,
Whose will be done.
Though dim as yet in tint and line,
We trace thy picture's wise design,
And thank Thee that our age supplies
The dark relief of sacrifice,
Thy will be done.
And if, in our unworthiness,
Thy sacrificial wine we press;
If, from Thy ordeals hearted bars,
Our feet are seamed with crimson scars,
Thy will be done.
Strike, Thou the Master, we the keys,
The anthem of the destinies.
The minor of Thy loftier strains
Our hearts shall breathe the old refrains,
Thy will be done.

The Memorial Service was concluded with a musical selection, "Prayer" (Guion), given by Mr. Bob McDaniel, accompanied by Miss Lola Watson.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Tuesday Morning, April 18, 1950

Auditorium, St. Edwards Nurses' Residence

The meeting was called to order by Chairman Hinkle.

The scientific program proceeded in order.

Chairman's Address—C. G. Hinkle, Batesville.

"Report on a Clinical Pathological Case," E. C. Moulton, Jr., Fort Smith.

"Manifest Refractions," A. N. Lemoine, Jr., Kansas City, Kansas.

A round-table luncheon followed.

Tuesday Afternoon, April 18, 1950 — 2:00 P. M.

The meeting was called to order by Chairman Hinkle.

The scientific program proceeded in order.

"Serous Otitis Media," Paul L. Mahoney, Little Rock.

"Laryngeal Tumors, Classification and Diagnosis," James B. Costen, St. Louis.

"Vitamin A in Tinnitis," Louis K. Hundley, Pine Bluff.

Officers elected are:

Chairman—Paul L. Mahoney, Little Rock.

Vice-Chairman—C. G. Hinkle, Batesville.

Secretary-Treasurer—K. W. Cosgrove, Little Rock.

Delegate—John W. Smith, Little Rock.

Alternate—L. Gardner, Russellville.

FOURTH GENERAL SESSION

April 18, 1950 — 1:30 P. M.

The meeting was called to order by President Smith and the scientific program proceeded in order.

"Carcinoma of the Colon and Rectum," S. W. Hawkins, Fort Smith (Lantern Demonstration).

"Established Factors in Carcinogenesis with Particular Reference to a Continuing Cause or Viral Agent," William O. Russell, Houston, Texas.

"Breast Cancer, A Brief Review of Theory and Therapeutics," W. G. Cooper, Robert Jones and Henry Hollenberg, Little Rock (Lantern Demonstration).

"Blue Cross-Blue Shield Reports," Ellery C. Gay, Little Rock.

"Post-Operative Complications of Gall Bladder Surgery," Col. W. W. Nichols, M. C., Army and Navy General Hospital, Hot Springs (Lantern Demonstration).

"The Acute Obstruction of the Small Bowel," Frank Kumpuris, Little Rock (Lantern Demonstration).

Tuesday Evening, April 18, 1950

The Sebastian County Medical Society was host at a social hour and banquet at the Goldman Hotel, followed by a dance at the UCT Winter Garden.

FINAL GENERAL SESSION

April 19, 1950 — 9:30 A. M.

The meeting was called to order by President Smith and the scientific program proceeded in order.

"Translumbar Aortography, Its Value in Diagnosis, Management and Prognosis of Renal Pathology," Watterson Reagan, Little Rock (Lantern Demonstration).

"Tularemia, the Diagnosis and Treatment," Capt. Richard R. Taylor, M. C., Army and Navy General Hospital, Hot Springs (Lantern Demonstration).

"Function of the Eye Bank and the Technique of Corneal Transplants," K. W. Cosgrove, Little Rock (Lantern Demonstration).

"Newer Concepts in Treatment of Arteriosclerotic Obliterative Disease," Peter O. Thomas, Little Rock (Lantern Demonstration).

"Ectopic Pregnancy," Melvin R. McCaskill, Little Rock (Lantern Demonstration).

FINAL SESSION, HOUSE OF DELEGATES

Wednesday Afternoon, April 19, 1950
2:00 P. M.

The House of Delegates was called to order by President Smith. The following delegates and members seated as delegates by action of the House (Motion, Hundley-Rush) were present:

ASHLEY—W. R. Cothern; BENTON—K. A. Siler; BRADLEY—W. J. Hunt; CARROLL—J. F. John; CHICOT—H. W. Thomas; CRAIGHEAD-POINSETT—Joe Verser; CROSS-ST. FRANCIS—J. O. Rush; DESHA—H. T. Smith; DREW—C. Lewis Hyatt; FRANKLIN—C. C. Long; GARLAND—Frank Adams; HEMPSTEAD—Jim McKenzie; JACKSON—K. K. Kimberlin; JEFFERSON—Louis K. Hundley; JOHNSON—James M. Kolb; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LITTLE RIVER—N. W. Peacock, Jr.; LOGAN—I. H. Jewell; MADISON—Charles Beeby; MILLER—R. R. Kirkpatrick; POPE-YELL—Roy I. Millard; PRAIRIE—J. C. Gilliam; PULASKI—T. Duel Brown, Edwin F. Gray, Charles R. Henry, Edgar J. Easley, Fred Harris, Daniel Autry, Frank Kumpuris, John W. Smith, Robert Jones, George Steinkamp, Elvin Shuffield, M. R. McCaskill; SEBASTIAN—Fred Krock, T. P. Foltz; SEVIER—C. E. Kitchens; UNION—H. J. Mayfield; WASHINGTON—V. O. Lesh; EENT SECTION—R. J. Calcote.

Other members of the House of Delegates present were:

President Smith, President-Elect Hunt, Councilors McDaniel, Monfort, Drennen, Hundley, Wilson, Dickinson, Gay, Owens and Richardson; Past-President H. T. Smith, Archer, Allbright, Shuffield, Evans and Norwood and Secretary Brooksher.

L. H. McDaniel presented the report of the Nominating Committee:

President-Elect—Charles R. Henry, Little Rock; J. O. Rush, Forrest City.

First Vice-President—Fred H. Krock, Fort Smith.

Second Vice-President—Ross Fowler, Harrison.

Third Vice-President—G. L. Hardgrave, Clarksville.

Secretary—W. R. Brooksher, Fort Smith.

Treasurer—Daniel H. Autry, Little Rock.

Councilor, Second District—J. J. Monfort, Batesville.

Councilor, Fourth District—Louis K. Hundley, Pine Bluff.

Councilor, Sixth District—R. C. Dickinson, Horatio.

Councilor, Eighth District—John W. Smith, Little Rock.

Councilor, Tenth District—Fount Richardson, Fayetteville.

Delegate, American Medical Association—W. R. Brooksher, Fort Smith.

Alternate, American Medical Association—Joe F. Shuffield, Little Rock.

By motion (Kolb-Dickinson) report of the Nominating Committee was accepted.

By motion (Kolb-Owens) all nominees other than president-elect were elected by acclamation. The Delegates then cast votes for president-elect.

By vote of the Delegates, Charles R. Henry was elected president-elect.

The report of the Reference Committee was read by Fred H. Krock, chairman.

REPORT OF THE REFERENCE COMMITTEE

FRED H. KROCK, Chairman

The following committee reports, which bear no specific recommendation, are accepted and approved as prepared and presented in The Journal of the Arkansas Medical Society for March, 1950, and as presented or supplemented at the meeting of the Arkansas Medical Society April 17, 1950:

1. Press Committee.
2. Military Medicine Committee.
3. Veterans Administration Committee.
4. Public Health Committee.
5. Liaison Committee with the Arkansas Medical and Hospital Service, Inc.
6. Cancer Control Committee.
7. Maternal Welfare Committee.
8. Committee for Liaison with the State Hospital for Nervous Disorders.
9. Liaison Committee with the Arkansas State Board of Health.
10. Report of the Executive Secretary.
11. Liaison Committee between the Arkansas Medical Society and the Arkansas State Board of Health.
12. State Medical Board of the Arkansas Medical Society.
13. Arkansas Cancer Commission.
14. Delegates to the American Medical Association.

The Scientific Exhibit Committee

This Committee has done an extensive amount of work. The report of the Committee is approved and the members of the Committee congratulated for the results which have been obtained. The following recommendations are approved:

1. That an annual award be given to the best scientific exhibit at future annual sessions of the Arkansas Medical Society, and that the Society be empowered to accept donations for such a purpose.

2. That adequate financial support, not to exceed one hundred dollars, be given by the Arkansas Medical Society to defray the expenses of the scientific exhibits.

Report of the Scientific Program Committee

The program which this Committee has arranged for the meeting this year speaks for itself. The Committee is to be congratulated on the presentation of symposiums on obstetrics and gynecology as well as cardio-vascular diseases. The Committee makes the following recommendation, which is approved:

That the House of Delegates appropriate a given fund and that this fund be turned over to the chairman of the Program Committee each year for use in obtaining out-of-state speakers.

Legal Affairs Committee

The Reference Committee approves the report of this Committee and the following recommendations which are made:

1. That any known violation of the Medical Practice Act, first be reported to the chairman of this Committee, in writing, with as much evidence as possible. It is to be desired, if possible, that such notice or request for investigation come from the county society involved or from the nearest society if the county involved is not organized.

2. We recommend that at present no change be made in the annual registration fee.

3. We recommend that in the near future the state Society, through its Legislative Committee, cooperating with the State Board of Examiners, begin to think about either rewriting or bringing up to date the existing Medical Practice Act.

4. We also recommend that the State Board of Examiners in a like manner use the offices of the Legal Affairs Committee in any way they see fit, to bring before the state Society any question requiring official action.

Medical Service Committee

The report of this Committee is accepted and approved. The following recommendations are made, which we feel are worthwhile and advise their acceptance by this Society:

1. We recommend that the state Medical Society endorse a medical student loan program for the State of Arkansas, and either set up a sufficient fund from Medical Society funds or initiate legislation providing for state funds for such a purpose. It is the feeling of this Committee that the obtaining of state funds for this purpose would be expedited by limiting the medical training of the beneficiary to the Arkansas Medical School.

2. We suggest that the University of Arkansas School of Medicine require each senior student to serve a two-weeks preceptorship with a general practitioner. We think that preferably this practitioner should be located in a small community or in a rural area. We think that this would do much to educate the student and to create interest in general practice.

3. We recommend that the state medical society each year sponsor a dinner at one of the hotels in the city where the meeting is held, to which would be invited all

the residents and assistant residents in the approved hospitals in Arkansas.

4. We suggest also that the University of Arkansas School of Medicine, through the University Hospital, endeavor to create a two-year rotating internship which is primarily for men who wish to go into general practice.

Industrial Health Committee

The report of this Committee is accepted and approved. The following recommendations are made, which we present for approval by the House of Delegates of the Society:

1. That if the physician in charge feels that a patient's confidence is violated in answering items 9, 10, and 11 on the standard form for the initial surgeon's report of compensation injuries, that he should secure an authorization from the patient before submitting information.

2. That members of the Society cooperate in reporting occupational diseases to the Department of Health as required by statute.

3. That long-range plans for setting up rehabilitation centers for industrial casualties be encouraged by the state Medical Society.

Mental Hygiene Committee

The Reference Committee accepts and approves this report. This very comprehensive report is worthwhile of detailed study by every member of the Society. The Reference Committee wishes to congratulate this Committee for this detailed report. The Committee makes the following recommendations, which we feel are worthwhile of adoption by the state Society:

1. The Medical Society offer the services of the members of the Mental Hygiene Committee to the Crime Study Commission in working out laws covering sex crimes and chronic offenders of all types.

2. The development of an adequate psychiatric service to the penal and correctional institutions of the state, as previously recommended by the Committee.

3. The Committee recommends that a bill be drafted and submitted to the Legislature providing for the establishment of a board of psychiatrists to examine all criminal cases where insanity is a plea and the findings of the State Hospital examiners are contested by either the prosecution or the defense.

4. The establishment of a separate institution near one of the teachers' training colleges in the state for the retarded children requiring institutional care.

5. The mental hospitals in the state are greatly overcrowded. In the future planning, to provide adequate hospital beds for the mentally ill, it is recommended that the Little Rock Unit be planned as the admission, diagnostic, acute treatment, research, and personnel training unit. This unit should not exceed 1,500 beds and should be planned in conjunction with the state medical center. Plans should also be prepared for the building of an additional psychiatric unit to be located in some other area of the state, the location to be designed by the Board of Control of the State Hospital. This unit should consist of approximately 500 beds for continued treatment of cases of mental illness, as well as approximately 500 beds for geriatric cases requiring custodial and nursing care.

Committee On the Auxiliary

The Reference Committee accepts the report of this Committee, and wishes to commend it for the excellent work it has done in compiling the history of pioneer doctors in Arkansas, and for the recent additions which have been added to this report. The following recommendations are approved:

1. All county medical societies which have no Auxiliary are urged to give permission and support to the immediate formation of such Auxiliaries.

2. Allowance of $150.00 for printing of the minutes and reports for the year. (Cost averages $175.00.)

3. Travel allowance of $500.00 for the President and $100.00 for the President-Elect should be continued on a reimbursement basis.

4. Allowance of $25.00 for membership in the Arkansas Legislative League, provided that the Arkansas Medical Society continues its membership.

5. Representation on the Committee for the Extension of Medical Care on a councillor district basis. (One Auxiliary member from each district.)

Rural Health Committee

Report of the Committee is accepted and approved and the following recommendations are approved:

1. Increased Society participation in the organizing of county health councils.

2. The full cooperation with the support by the Society of the University of Arkansas Extension Department on Health Education on behalf of our rural people. In addition, a vote of appreciation by the Society to Mr. Aubrey Gates and Miss Helen Robinson, health specialists with the Extension Department, for the outstanding work they have done in organizing the Arkansas Health Council.

3. Increased attendance of Society members at the Annual Conferences on Rural Health.

Postgraduate Study Committee

The report of this Committee is accepted and approved and the following recommendations are approved:

1. It is recommended that committee appointments for the following year be announced in April immediately after the Annual Session of the Society so that the chairmen and members of the committees may accomplish something in the way of planning and organization before autumn. Since appointments are made September 14th, and final committee reports must be in by February 10th of the following year, little time for committee work is allowed.

2. It is again recommended that ten members be appointed to the Committee on Postgraduate Study, two members for five years, two members for four years, two members for three years, two members for two years, and the remaining two members for one year each. It is recommended that two new members be appointed each year to replace those retiring, newly appointed members to serve five years each. This arrangement will give a more permanent organization so that long-range plans for postgraduate medical study may be considered. It is further recommended that two members of the Committee be appointed from each of the four corners of the state and the remaining two members be appointed from the central part of the state. This will allow the local committee members to set up postgraduate study sessions in their own part of the state, thus bringing speakers nearer to those physicians who may be interested in attending the meetings.

Child Welfare Committee

The report of this Committee is accepted. The Reference Committee is in accord with the report and recommendations as submitted with the exception of the fee schedule as outlined. It would seem that in setting up such a fee schedule a precedent is being established which could easily be followed by any of the other lay organizations dealing with specific diseases. In other words, this precedent might be followed by the Cancer Society with regard to cancer cases, or the American Heart Association with regard to cardiac cases, or the Association for the Blind in the treatment of eye condi-

tions. We see no reason whatsoever for the National Polio Foundation to pay for the medical care of patients who are able to pay. In the case of the indigent patients, we think that it is a very worthwhile project. We feel that the following recommendations should be considered for adoption:

1. That professional individuals and groups, hospitals, and official state and voluntary agencies should coordinate their energies and resources in a unified manner in the problem of making care available to those who need it with poliomyelitis.

2. That this program of care should be planned so as to maintain contact between the patient and family and in such a manner that it preserves the doctor-patient relationship.

3. That hospital facilities for acute and convalescent care should be increased by encouraging the general hospitals in the larger cities of the state to accept and care for poliomyelitis patients.

Hospital Relations Committee

This report is accepted and approved with certain modifications of some of the recommendations made by it. On the whole, the Reference Committee is highly in accord with efforts of this committee to separate hospital services from professional services. In the session of the Arkansas Medical Association in June, 1949, the recommendation was adopted that the Arkansas Medical Association go on record as disapproving the hospital practice of medicine. The following recommendations are approved:

1. That so far as possible the medical cost of hospital care be separated from the non-medical cost, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.

2. That each hospital department be self-supported so that neither the hospital nor the physician rendering the service shall exploit the patient or each other.

3. That fees for medical services, which are collected by the hospitals, be established with a representative committee of the staff to include the head of the department, the administrator and the executive medical staff.

4. That the basis of financial arrangement between hospitals and physician may be salary, commission, fees, or such other method as will best meet the local situation with due regard to the needs of the patient, the community, the hospital and the physician.

5. That bills for medical service be rendered in the name of the physician or physicians performing the services.

6. That the heads of the departments of radiology, pathology, anesthesiology and physical medicine be only selected by hospitals in accordance with the accepted methods of appointment of physicians to staff positions in other specialty services of the hospital, and that no physician heading a department of radiology, pathology, anesthesiology or physical medicine shall be separated from staff appointment by the administrator or governing board of a hospital without the knowledge or approval of the governing medical staff.

7. At the suggestion of Mr. Eugene R. Warren, counsel for the Arkansas Medical Society, it is recommended that a new medical practice act be drawn up and presented to the 1951 Arkansas Legislature for consideration.

With regard to the recommendation that the Arkansas Blue Cross policy shall provide payment for hospital services only, and that payments for all medical services, including pathology, radiology, anesthesiology and physical therapeutic services, shall be included in the Blue Shield policy, it is our feeling that this recommendation should be discussed fully with officials of the Arkansas Medical and Hospital Service, Inc., before coming up for consideration by the House of Delegates. The Blue Cross and Blue Shield are our chief defenses against compulsory health insurance, and we would hesitate at this time to jeopardize the use of these weapons in any way whatsoever with the public.

Medical Education Committee

The report of this Committee is accepted and approved. The following recommendations are made which are submitted for approval by the House of Delegates:

1. That this Committee recommend to the House of Delegates that they oppose any and all forms of subsidization of medical education which will in any way involve federal control of the medical agency concerned.

2. That this Committee recommend to the House of Delegates that they lend all possible efforts to the immediate construction of the new medical center in the securing of adequate funds for the operation.

3. That the membership of the Arkansas Medical Society be requested to use this Committee as a proper channel by which to refer any suggestions, counsel, etc., concerning the School of Medicine.

4. That a copy of all publications, committee appointments, etc., of the Arkansas Medical Society be sent to the Dean of the School of Medicine for his information and record.

5. That the School of Medicine attempt to institute a better system of referral of patients to the University Hospital and the Isaac Folsom Clinic.

6. That this Committee urge the House of Delegates to use every possible means to have Act 346 repealed, which is the law requiring admission to the School of Medicine on a congressional district basis.

7. That this Committee wishes to go on record commending the present administration for the efficient manner in which they are handling the situation.

Heart Committee

The report of this Committee is accepted, but we would like to call your attention to the recommendation that other heart disease detection centers are to be considered for other locations within the state. The Reference Committee is reluctant to approve the setting up of such centers for the benefit of the population of the state as a whole, inasmuch as we feel that this is the beginning of another encroachment upon the private practice of medicine.

Report of the Treasurer

The books were found to be in order, and the Treasurer is commended for his work of the year.

Report of the Secretary

The report of the Secretary is accepted, approved, and commendation given.

Report of the Legal Counsel of the Arkansas Medical Society

The report of the Legal Counsel is accepted, and we recommend the adoption of the following recommendations:

1. That studies be made several months prior to the next legislative session of legislation thought to be beneficial to the public and to the profession.

2. That studies be made to determine the advisability of preparation of a modern medical practice act.

3. That the opposition to the principle of socialized medicine be continued without let-up.

4. That the practice of submitting requests for legal opinions only through the Secretary's office be continued.

Legislative Committee

The report of this Committee is accepted. It was the feeling of this Committee that we should wait until the Legislature of 1953 to introduce a modern medical practice act for Arkansas. This question was discussed in the report of the Hospital Relations Committee, and in view of the urgency of the necessity for such an act, as well as a recommendation of our counsel, Mr. Warren, that such an act be presented to the Legislature in 1951, we would advise that the House of Delegates encourage the Legislative Committee to proceed with the completion of such a modern medical practice act for submission to the Legislature in 1951.

Council Report

The report of the Council is accepted, and the following recommendations are approved, with the exception of No. 6, which was amended at the first session of the House of Delegates:

1. Approved Life Member applications from: E. C. Hunt, Ola, Pope-Yell County; S. M. Graves, Clarksville, Johnson County; W. B. Gould, Glenwood, Howard-Pike County; W. H. Toland, Nashville, Howard-Pike County.

2. Approved Affiliate Member application from C. N. Bogart, Forrest City, Cross-St. Francis County.

And recommended their acceptance by the House of Delegates.

3. Recommended to the House of Delegates that county societies be impressed with the importance of and remit immediately 1950 American Medical Association membership dues for every member and recommended to the House of Delegates that Article XI of the Constitution be amended to read by adding the following at the end of the second sentence: . . . "Provided, that membership in this Society shall be restricted to those who possess the qualifications set forth in Article IV and who pay the annual dues of the American Medical Association in addition to dues to their component and state society." . . . This amendment to be drawn up by the Council Committee of Doctors Dickinson, Allbright and McDaniel.

4. Recommended that resolution be submitted to the House of Delegates to amend Article VI of the Constitution to include one Vice-Councilor from each medical district and appointed committee of Doctors Dickinson, Gay and Richardson to draw up the resolution.

5. Recommended the appointment of a Council committee composed of Doctors Dickinson, Gay and Richardson to consult with the Advisory Committee of the Arkansas Hospital Association in regard to recent complaints about the Hospital Division of the Arkansas State Board of Health.

6. Accepted report on reorganization of councilor districts composing the Arkansas Medical Society as submitted by the special committee, and recommended its adoption by the House of Delegates, amended to read that this change shall become effective on the first day of the Arkansas Medical Society Meeting in 1951.

7. Nominated Carl Rosenbaum and W. G. Cooper of Little Rock to Arkansas Cancer Commission (selection by the Governor).

8. Recommended that the following resolution be passed by the House of Delegates of the Arkansas Medical Society: "In its constant effort to improve the health of our nation the American Medical Association has appointed our fellow-citizen, Aubrey D. Gates, as Field Director for Rural Health. Therefore, be it resolved that we heartily approve this selection, and pledge our hearty assistance in furtherance of the task in which he is engaged."

9. Recommended that the House of Delegates pass a resolution endorsing a national survey on physicians' incomes, to be undertaken jointly by the American Medical Association and the United States Chamber of Commerce, as published in the current issue of the Journal of the American Medical Association.

Resolution Presented by Dr. John Smith of the Pulaski County Medical Society for the Planned Parenthood Association of Arkansas

The Reference Committee is unwilling to recommend approval of the resolution that the Arkansas Medical Society go on record as favoring the introduction of birth control for the indigent and medically determined cases as a public health activity of the State Board of Health. It is felt that this should be carried on when indicated, as at present, by private practitioners.

By motion (Henry-Harris) the Reference Committee Report was amended to exclude the recommendation that one Auxiliary member from every District be added to the Committee for the Extension of Medical Care.

By motion (Kolb-Brown) the Reference Committee Report, as amended, was accepted.

By motion (Richardson-Gray) the Reference Committee was commended for its excellent work.

John H. Wilson read a supplementary report of the Council.

SUPPLEMENTARY COUNCIL REPORT

The Council of the Arkansas Medical Society met at the Goldman Hotel in Fort Smith on Tuesday, April 18, with the following action taken:

1. Recommended that the House of Delegates pass a resolution to present an honorarium from the Arkansas Medical Society to R. B. Robins of Camden in appreciation of the services devoted to this Society and to the cause of American medicine.

2. Recommended to the House of Delegates that the $10,000.00 loan made by this Society to the Arkansas Medical and Hospital Service, Inc., be repaid over a period of five years at the rate of $2,000.00 a year. This annual sum, during that time, is to be used for necessary executive purposes of the Society. Should the loan be more conveniently repaid in one lump sum, the money received will be used by the Society at the aforementioned rate for the same purpose.

3. Ordered expenses paid for the 74th Annual Session and granted the annual Secretary's honorarium.

The Council of the Arkansas Medical Society met at the Goldman Hotel in Fort Smith on Wednesday, April 19, with the following action taken:

1. Approved and recommended to the House of Delegates for adoption the following amendment to the Constitution:

Amend Section 2, Chapter VII, of the By-laws by adding at the end of said Section, the following: A Vice-Councilor for each district shall be chosen at the same time and in the same manner as the Councilors are selected. The duties of the Vice-Councilors shall be to assist the Councilors in the performance of their duty, to act in their stead at all meetings in the absence of the Councilor, to attend meetings of the Council and to

vote in the absence of the Councilor, provided that the Vice-Councilor shall have the privilege of the floor at all meetings.

2. Recommended that Louis E. Gebauer, Ph.D., Secretary of the Basic Science Board, that his suggestions for combining the offices of the State Medical Board, the Basic Science Board and the Arkansas Medical Society executive offices in Little Rock, is not feasible at the present time but will be considered at a later date.

3. Approved and recommended for adoption by the House of Delegates the following resolution:

WHEREAS, distinguished and loyal service should not be allowed to pass unnoticed, but should be called to the attention of those for whom much efforts are performed, and

WHEREAS, by his untiring and long-continued labors to bring the message of freedom of enterprise as opposed to a hampering restraint on initiative and industry, as applied to the practice of medicine, our colleague, R. B. Robins, has rendered a service of signal importance not only to his professional brethren of this nation, but to all citizens who cherish freedom of opportunity, therefore

BE IT RESOLVED, that the thanks and appreciation of the Arkansas Medical Society be tendered to Doctor Robins who has been an inspiration to us in his continued personal opposition to the philosophy of Socialism which is now engaging the attention of the people of our Republic.

4. Approved and recommended for adoption by the House of Delegates the following resolution:

WHEREAS, the increasing trend toward Socialism in this country is a matter of grave concern to all citizens, and

WHEREAS, doctors, as citizens, deplore trends in our national life, which, if continued, would deprive Americans of the heritages and of the principles which have made our great nation, and which have given us the American way of life, and

WHEREAS, the democratic way to restore our American way of living, freedom of initiative and private enterprise rests in the election of officials in state and national government who feel that the American way of living is earnestly to be desired, and that present trends should not only be curtailed and curbed, but in many instances should be reversed, therefore

BE IT RESOLVED by the Arkansas Medical Society in Annual Session assembled at Fort Smith, Arkansas, that as a medical society, we do not endorse any candidate, that we urge each doctor of medicine in the State of Arkansas to assert his right to vote for officials in national and state governments who sincerely support and who desire to perpetuate the standard of living under which America has progressed, and that we call upon every doctor in Arkansas to use his unfailing energy in every possible way to secure the earnest cooperation of all citizens in voting for these officials without respect to personalities or political tenets, but with sole regard to preservation of the American way of living, and

BE IT RESOLVED, that this resolution be forwarded to the President of the United States, the Arkansas members of Congress, the American Medical Association and all state medical societies.

5. Recommended that the salaries of Mr. Sid Wrightsman, Jr., Executive Secretary, be increased in amount of $35.00 monthly, and Executive Secretary's stenographer $15.00 monthly.

By motion (Dixon-Brown) the supplementary report of the Council was accepted.

By motion (Dixon-Hundley) B. L. Bailey of Star City and G. C. Wood of Grady were awarded the status of Life Member and Affiliate Member, respectively, in the Lincoln County Medical Society and the Arkansas Medical Society.

Past-President C. A. Archer read the following resolution:

> The generous hospitality and the warm fellowship extended by the Sebastian County Medical Society at this gathering has never been excelled in all the history of our Society. We will ever feel that a bounty of friendship has been given us that shall forever be cherished by all.

By motion (Brown-Harris) the resolution commending Sebastian County Medical Society was adopted.

By motion (Hundley-Henry) the Reference Committee at future Annual Sessions of the Arkansas Medical Society will be composed of two separate committees in order that the work may be divided equally.

By motion (Rush-Brown) the House of Delegates adjourned.

FINAL GENERAL SESSION

Wednesday, April 19, 1950

Immediately following adjournment of the final session, President Smith called the final general session to order.

The following past-presidents were seated on the rostrum: H. T. Smith, C. A. Archer, Sam Allbright, Joe Shuffield, L. T. Evans and M. L. Norwood. President Earle H. Hunt was escorted to the rostrum by H. T. Smith and was given the gavel by President Smith, who spoke briefly, expressing gratitude to the Society for the courtesies extended him during his term as president. President Hunt made a brief address. Secretary Brooksher read a congratulatory telegram to President Hunt from the Benedictine Sisters at Clarksville. President-Elect Charles R. Henry was escorted to the rostrum by Daniel Autry and Edwin F. Gray and he thanked the Society for his election.

By motion (Dixon-Kolb) the Society accepted an invitation of the Pulaski County Medical Society, extended by Daniel Autry, to meet in Little Rock in 1951.

By motion (Brown-Hundley) the Society adjourned sine die.

Registration—1950 Annual Session

Members, 316; visitors, 43; exhibitors, 42; medical students, 4. Total, 405.

The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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Extensive studies* by the Bureau of Human Nutrition have established that breakfasts rich in protein and supplying 500 to 700 calories, effectively promote a sense of well-being, ward off fatigue, and sustain blood sugar levels at normal values for the entire morning postbreakfast period.

These physiologic advantages are related mainly to the protein content rather than to the caloric content of the breakfast. In fact, when isocaloric breakfasts were compared, those with the higher amounts of protein led to the greatest beneficial effects. Breakfasts providing the lower quantities of protein (7 Gm., 9 Gm., 16 Gm., and 17 Gm. respectively) produced a rapid rise in the blood sugar level and a return to normal during the next three hours. Breakfasts providing more protein (22 Gm. and 25 Gm. respectively) produced a maximal blood sugar rise which was lower than that following the breakfasts of lower protein content, but the return to normal was delayed beyond the three hour period.

The subjects on the higher protein breakfasts "reported a prolonged sense of well-being and satisfaction." The findings indicated that the beneficial effects of the high protein breakfast on the blood sugar level may extend into the afternoon.

Meat, man's preferred protein food, is a particularly desirable means of increasing the protein contribution of breakfast. The many breakfast meats available are not only temptingly delicious and add measurably to the gustatory appeal and variety of the morning meal, but they also provide biologically complete protein, B-complex vitamins, and essential minerals. *Meat for breakfast, a time-honored American custom, is sound nutritional practice.*

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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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ENDOCRINE THERAPY IN OBSTETRICS AND GYNECOLOGY *

EUGENE T. ELLISON, M. D.
Texarkana

The use of endocrine products in the treatment of functional obstretrical and gynecological disorders has been the topic of an extensive number of publications in our modern medical literature. There is as much or more written on the effects of the known endocrine extracts on the reproductive organs of laboratory animals. It is unfortunately true that the results obtained by using these substances in laboratory experiments, have been the basis on which clinicians have advocated extensive use of endocrine preperations in menstrual disorders, threatened abortion, sterility and other related clinical disorders. Such enthusiastic claims have, in most cases, been disappointing, because clinical conditions are not so simple in character as experiments carried out in the laboratory. One has only to consider the phenomena of menstruation which occurs only in humans and certain apes, to realize that correlation between laboratory work and clinical conditions is limited in scope.

An astonishing number of substances with some known hormone activity when assayed in the laboratory, are available for clinical use. Many of these products have some specific effects when given to patients. These products are, however, offered commercially under a confusing array of names, are suggested to be useful in the treatment of many disorders of the human female, and all are accompanied by references to original publications substanting these claims. However, there are as many or more publications that deny many of the specific uses ascribed to these agents.

All clinicians who have practiced over a number of years know that many functional disorders of the female are self-limited in nature. Many now believe that the human female does not ovulate every month, but some ten times per year, thus having about two anovulatory periods per year which may or may not be accompanied by a menstrual disorder. Such regularly occurring irregularity of function (1), accounts for many cures which occur spontaneously to patients taking medications from well meaning clinicians. This also accounts for cures by impotent medications and quackery in general.

It is not to be implied that the treatment of disorders of menstruation, abortion, sterility, etc., are this simple, because many such disorders are signs of a most defective of fundamentally diseases individual. These diseases reach such extremes as ovarian agenesis, infantile uteri (2) and other congenital abnormalities. They are accompanied, often, by systemic evidence of endocrine diseases such as are featured in circus side shows and textbooks on endocrinology. All practitioners are struck by the rarity of these gross endocrine deformities and are more interested in the treatment of the relatively minor deviations from normal, that are the most frequent type patient seen in our offices today. Fortunately for all concerned, these are more amendable to treatment.

The first principle of treatment consists of amplifying the chief complaint which brings the patient to the office, into a concise history of her mature life. A thorough examination of the individual for deviations from normal, must be carried out. In no case is treatment to be administered to the patient for the presenting complaint, until a study of the patient as a whole, and the status of the reproductive organs has been ascertained by physical examination and appropriate laboratory procedures. One is astonished by the many systemic conditions which are found accompanying functional disorders of reproduction. By the simple expedient of glancing through the card index of our offices, the following conditions were most frequently found:

1. Obesity of many types.
2. Underweight individuals.
3. Poor physical development.
4. Emotional exhaustion, emotional instability, inadequate personality or other personality defects.

*Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 17, 1950.

5. Anemia.
6. Poor nutrition.
7. Hypothyroidism.
8. Pituitary dysfunctions.
9. Common debilitating diseases.
10. Hypo-ovarianism, either primary or secondary.
11. Mild familial glandular patterns.
12. Incompatability due to different personality types.

It is beyond the scope of this presentation to discuss the management of the constitutional states, but it must be emphasized that this is in most cases the cardinal principle of scientific management.

Certain of these constitutional states deserve mention since they modify more specific therapy. Among these are personality types and psychological aspects (3).

All are familiar with the fat, amiable, sympathetic, easy-going woman who has some disorders of menstruation probably referable to this lethargy. Less disorders are seen from the strong, well muscled, aggressive, early-rising individual. A third personality type, namely the skinny, shy, introspective, tense, nervous, late-rising individual with nervous energy, has many disorders often quite resistant to therapy. To carry proper treatment of these disorders through the complete and lasting cures, the patient must be convinced of the true interest of the clinician. The psychological aspects of menstrual disorders are well illustrated by the college girl who is anemorrheaic for several months after first leaving home. There is no better psychological treatment than a most complete examination. Endocrine products are of value in these systemic conditions as metabolic stimulants including thyroid extracts, insulin, adrenal cortical extracts, ovarian substances and others (4). It is the duty of the physician to be able to ascertain these systemic conditions from an office examination and simply laboratory studies including the basal metabolism rate, chest X-ray and body mensuration. The local gynecological conditions can be ascertained, I believe, adequately by a thorough spectulum and digital examination of the female pelvis plus a study of vaginal smears and endometrial biopsy. The interpretation of these latter procedures are available to all Arkansas physicians either through consultation with local pathologists or through the facilities of the departments of Pathology, and Obstetrics and Gynecology of your State University.

With this study of the general conditions of the patient and an estimate of the functional capacity of the pelvic viscera, one may then resort to the use of the endocrine products with a much more successful outcome. It is our purpose to briefly discuss the most widely accepted of these substances.

Thyroid extract mentioned above, used with a depressed BMR, or in small doses with a normal rate, has proven most effective in many menstrual disorders, relative sterility, threatened abortion, premenstrual tension, etc. (5). The entire rational is lacking, but clinical experience here cannot be denied. It becomes a mandatory supplement to any other therapy. Physicians who wish to obtain an accurate metabolic determination in their offices should either repeat their metabolic tests twice or give a mild sedative the night before the patient reports for the BMR. Thyroid extract can then be administered within the tolerance dose of the individual. This popular product can safely be used in the majority of disorders that come to your office and can be used in conjunction with any of the products to be mentioned later.

The second most effective and widely used products are natural occurring and synthetic estrogens (6). These products find more specific usefulness in the vasomotor symptoms of the surgical castrate or the menopausal woman, but neither need take other than oral medications. The use of large doses such as 25 mgs. silbesterol as a styptic for menorrhagia is striking, but not without side effects. These synthetic estrogens in large doses are often nauseating but are tolerated better when B-complex vitimins are given at the same time (7). These vitamins apparently speed the elimination of the estrogen. The use of large amounts of estrogen during pregnancy for prevention of habitual abortion is not convincing although used rather widely (8). Large doses are tolerated during pregnancy. This fact may be utilized as an inexpensive, but not entirely reliable pregnancy test. There are most reliable reports nevertheless, that larger doses of estrogen given throughout pregnancy increases the survival rate of babies of diabetic mothers (9). Large dose therapy controls temporarily the symptoms of endometrosis, but management and estrogens is more successful. Estrogens are most effective in relief of post-delivery breast engorgement and in menorrhagia occurring in the early months following childbirth (10). When administered throughout the menstrual interval with or without progesterone, in cyclic manner, the regulation of many minor disorders of menstruation ensues. The

scientific effectiveness of this treatment has not been proven, nor has the value of artificially inducing menstruation by this method been proven of value. The combination of thyroid therapy with cyclic estrogen administrations apparently controls many cases of functional bleeding. Estrogen therapy is premenopausal ("late thirties") patients with symptoms of physical letdown, etc. is disappointing. These frequently occurring disorders, called "the little menopause," respond more readily to general physical and psychosomatic therapy (11).

Progestrone, the hermone of the corpus luteum finds the most specific usefulness in the prevention of certain types of early abortion, where it is possible to show a deficiency of progesterone by pregnandiol excretion studies (12). This is of course, a minor percent of aborting patients, but offers hope for some cases subject to habitual abortion. Some merit exists for the use of this product in premenstrual tension states, after pains and mastalgia, but as a whole the results are infrequent and other forms of management are superior.

Pituitary sex hormones, chorionic hormones and equine gandotropic substances, have optimistic supporters of their value but in our experience, (and others), (13), their usefulness has been limited, and the prices prohibitive. Androgenic hormones, or the male sex hormones are useful os a "stop gap" in excessive functional bleeding, most widely used in control of pain in endometrosis, helpful in a few dysmonorrhea cases, premenstrual tension, and effective in menopausal vasomotor symptom control (14). Frigidity associated with certain psychosomatic conditions of the premenopausal years responds to the use of androgens (15).

Summary: Endocrine therapy in obstetrics and gynecology should be used only after a thorough study of the individual for general and local disorders. Laboratory facilities for completing most diagnoses are available to all Arkansas physicians. Personality types and psychosomatic disorders must be considered in prescribing treatment. Certain well defined indications for endocrine product therapy have emerged from a large number of clinical and laboratory reports. The most effective endocrine products are discussed briefly.

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REPORT ON TULAREMIA: ITS DIAGNOSIS, AND TREATMENT *

RICHARD R. TAYLOR, CAPTAIN, M.C.
Hot Springs National Park

This is a report on the diagnosis and treatment of thirty-five cases of tularemia which have been seen at Army and Navy General Hospital, Hot Springs National Park, Arkansas, during the past three years.

Tularemia is an infectious disease of most familiar lower animals, which has been demonstrated throughout most of the world, and is transmitted to man primarily through: (1) contact with infected animals by dressing carcasses or ingestion of insufficiently cooked meat; (2) through the bites of ticks, lice, fleas, and certain flies; (3) by inhalation of the causative organism; (4) by implantation in the conjunctival sac; (5) possibly through water, since it has been demonstrated in Russia in both ponds and streams.

The disease and organism were first discovered in 1911 by McCoy and Chaplan in Tulare County, California, during their first investigation of rodent plague in ground squirrels. In 1914 the first human infection was demonstrated by Wherry and Lamb and at that time wild rabbits were incriminated as the natural reservoir. In this particular region, ticks, rabbits, and squirrels are the primary known transmitting agents, particularly ticks. Prior to 1924 there had been only fifteen cases of tularemia reported in man, but at the present time about fifteen hundred cases per year are reported to the United States Public Health Service.

This disease may be divided into four main clinical groups. The first is the ulcerograndular

*Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 19, 1950.

type which is manifested by initial glandular enlargement followed in about twenty-four hours by an inflamed papule at the site of the primary contact. This papule breaks down and a small ulcer crater appears in the center, frequently with a black crust. There is usually no erythema between the initial lesion and the enlarged tender regional nodes. These nodes may suppurate in cases which receive no antibiotic treatment or late therapy with streptomycin or aureomycin. The second type is the glandular type which is similar to the ulceroglandular except no primary lesion is present at the site of the infection. The third type, the oculoglandular type, is similar to the ulceroglandular type except the primary lesion is in the conjunctival and the glands affected are the periauricular, parotid, submaxillary, anterior cervical, and axiliary nodes. The fourth type, the typhoidal type, are those cases in which no apparent primary lesion or glandular swelling is present. Fever, dehydration, weakness, stupor, and mental erration are the outstanding features of this latter type. The incidence of pneumonia in the typhoidal type is much greater and prior to antibiotic therapy a fifty per cent mortality rate was reported. In Arkansas tularemic pneumonia must be considered in every acute inflammatory disease of the chest, particularly when the patient's condition is more serious than would be expected from physical and X-ray findings. The characteristic lesions seen may be one of the following types: Lobular or bronchopneumonic processes, circumscribed parenchymal lesions, and pleural reaction with effusion whenever the pulmonary lesion reaches the viscereal pleura. It seems that the circumscribed lesions are an older stage and apparently represent partial resolution where the body is capable of handling the acute exudative process. Pulmonary abscess formation may occur.

The diagnosis of tularemia may be based on: (1) a significant or rising agglutination titer; (2) on animal inoculation with sputa or material aspirated from fluctuant nodes; or 3) on positive blood culture. The cases in this series were all confirmed by significant rising agglutination titers. A titer of 1:40 was considered suspicious and 1:80 or greater, diagnostic. The period from the onset of the illness to development of diagnostic titers ranges from seven to thirty-four days with an average of sixteen days. Agglutination titers have ranged from 1:80 up to as high as 1:40,960, the latter being seen in a case of pulmonary tularemia with abscess formation. The average highest titer following treatment is 1:1280. In all cases of pulmonary tularemia the patient is much sicker than in the other types and, in turn, apparently always develops a higher agglutination titer if he survives. The average highest titer for pulmonary tularemia is 1:5120. It is of interest that cross agglutination with brucellosis nearly always occurs but within a few days the tularemic titer becomes higher. A prozone phenomena was observed on many occasions. This is characterized by negative agglutination titers on the first three tubes, for example: 1:20, 1:40, and 1:80, and then positive titers up through 1:2560 with all higher dilutions negative.

All patients in this series were male veterans except for one soldier, and ranged in age from 19 to 66 years. Thirty-one were farmers, two were in the Forestry Service, and one was a teamster, and the last a soldier. All spent a good part of their time out of doors and most gave a history of frequent contact with ticks. Twenty-three of the thirty-five cases were transferred by ticks, one by chigger, four by rabbits, and in seven no obvious agent was present. The ticks responsible in this particular area are the Dermacentor variabilis and the Amblyomma americanus (the Lone Star tick).

Of these cases, twenty-three were of the ulceroglandular type (65.7%), one was a glandular (2.9%), one an oculoglandular (2.9%), and ten had the typhoidal type (28.5%). From these there were twelve cases of pleuropneumonic tularemia; all of the typhoid group and one each in the oculoglandular and ulceroglandular groups. Two cases of necrotizing tonsillitis were present which were felt to be on a tularemic basis and each occurring in patients with pneumonia. The average hospitalization for the ulceroglandular, oculoglandular, and glandular type of tularemia was twenty days, compared with nearly forty days in the cases with pneumonia. Two of the pneumonic cases went on to form pulmonary abscesses, one of these appearing on the tenth day of the illness and the other not appearing until the fifty-second day after the onset and despite apparent adequate doses of streptomycin early in the course of the disease.

It is of interest to note that two cases which were treated for ulceroglandular tularemia returned, one in two months and one in eighteen months, with a second, distinct, acute attack of ulceroglandular tularemia, with the site of the primary lesion in a different place than the original one seen. Both of these cases had been treated during their first attack very shortly after the onset of the disease; one on the day of onset and the other four days after onset of

clinical tularemia. It is felt that in cases where streptomycin or aureomycin therapy is given early after the onset of tularemia, that the patient has had no time to develop adequate antibodies to present a subsequent re-infection and that on reexposure they will develop tularemia.

The history and treatment of tularemia is very interesting but until 1946 no specific antibiotic was known which could cure tularemia. Foshay reported 600 cases in 1940 advocating the use of antitularemic serum which he felt to be effective in shortening the course and severity of the disease; however, so many reactions occurred (up to fifty per cent) that it was only recommended in seriously ill patients. In 1945 Jackson reported the treatment of sixty-one cases with intravenous bismuth sodium tartrate, without mortality. This compared with the overall mortality reported in other series ranging from three to five per cent. In 1946 Foshay and Pasternack reported on the use of streptomycin in the treatment of tularemia and it rapidly became the drug of choice. All other drugs and the antitularemic serum which had been previously employed fell by the wayside, none being consistently effective or showing the marked influence on the acute illness as stroptomycin. Since the report of Woodward et al in March 1949, aureomycin has come to the foreground as being as effective as streptomycin and possibly more so. At that time three cases of pulmonary tularemia were described with an effective cure with aureomycin therapy. Animal experimentation done prior to that time on mice indicated the marked efficacy of aureomycin.

The majority of cases in this series were treated with streptomycin, receiving various doses according to the type of illness. Originally ten grams were given at the rate of two grams per day and this gradually cut to a total dose of two grams in a single injection. In the uncomplicated ulceroglandular patient there appeared to be no difference in the results of those patients receiving two grams and those receiving ten grams, and consequently, it was concluded that the lesser doses were just as effective and consequently were to be recommended. This was not found to be true with pleuropneumonic tularemia. In all of these, streptomycin, 0.25 grams was given every three hours and continued until the patient was afebrile requiring an average of 22 grams. The immediate results were very striking in all treated patients except two, and in these clinical response was delayed four or five days. One patient died within twelve hours following admission and the autopsy demonstrated that the etiology of the multiple lung abscesses which were shown on X-ray were tularemic. It is interesting that following this patient's death his wife and daughter were examined because of similar symptoms and were also found to have acute pneumonic tularemia which responded to adequate streptomycin therapy.

In general, clinical improvement following antibiotic therapy preceded a fall in fever as much as twenty-four hours. Symptomatic care was given with particular attention to adequate hydration. The primary ulceroglandular lesions were covered with a dry dressing to prevent secondary infection and required two to three weeks to resolve, compared with the thirty-two days reported in one-hundred and eighty-one cases collected by Pullen and Stuart. 22.2% of their cases went on to suppurate compared with a single one out of our twenty-three cases, and this one was not seen for adequate treatment for two weeks following the clinical onset. In nearly all other cases, however, persistent lymphadenopathy was present but there was gradual regression of these nodes and none have reactivated so far.

From all present data, it appears that aureomycin is now the drug of choice for tularemia. We have had only two cases this spring and each was treated effectively with aureomycin. The first, a 33-year-old negro who was admitted on 12 January 1950, was found to have on examination a massive pleural effusion on the right. In the X-ray film an area of encapsulated fluid could be noted laterally, and considering this and the general condition of the patient a tentative diagnosis was made of pleuropneumonic tularemia and the patient started on streptomycin therapy. During the first five days of treatment he went downhill very rapidly despite the sterptomycin therapy and went into congestive failure. Tularemic pericarditis was felt to be present. A thoracentesis was done in an attempt to alleviate the pressure caused by the effusion but through three portals only 5 cc. of fluid could be removed and this was thick mucoid material. The patient was digitalized and started on aureomycin, 0.25 grams, q.i.d., continuing for a total of 9.5 grams. The same day, but following the institution of this therapy, the first positive blood agglutination report came back in a dilution of 1:5,120. Following this treatment marked clinical improvement was evident within twenty-four hours, and the patient made a spectacular

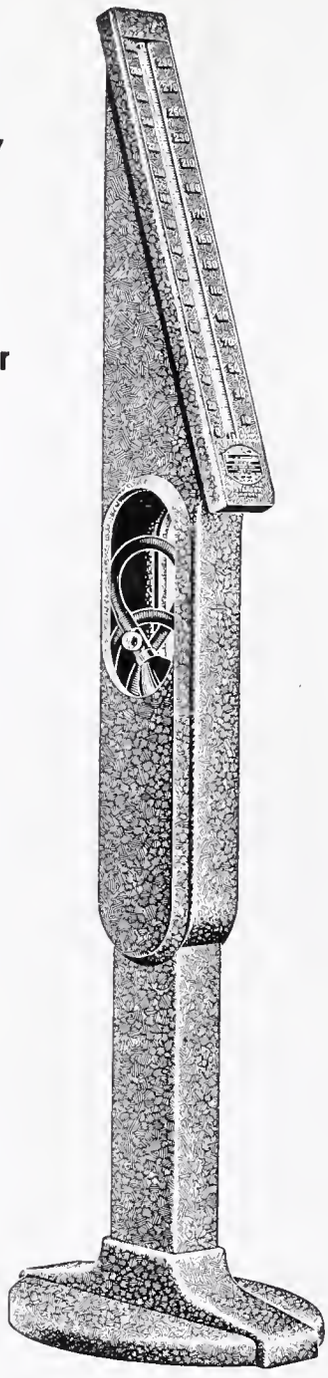
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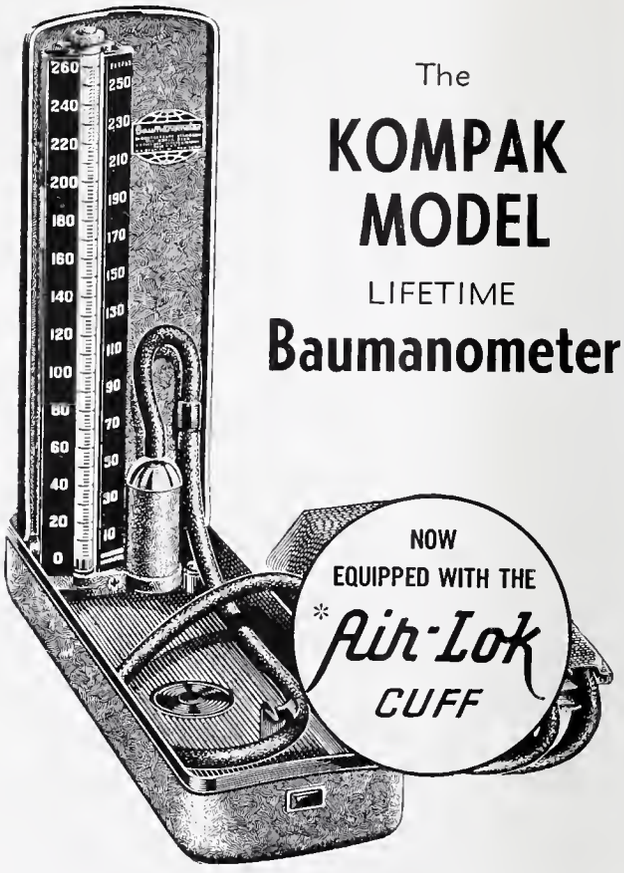


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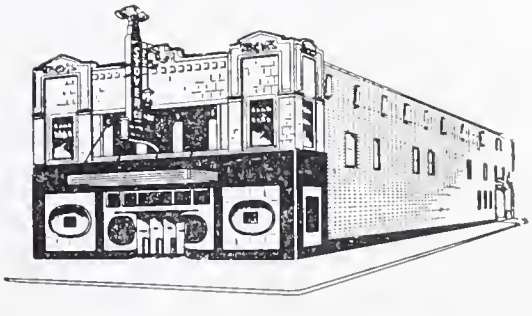
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and uneventful recovery. It was apparent that the streptomycin (total dose 20 grams) was not adequate for this patient in the dosage in which given (2 grams a day) and that the combination of digitalization and aureomycin therapy was effective, but no full credit may be given aureomycin because of combined treatment.

The second case was a typical ulceroglandular tularemia with a primary lesion in the left upper abdomen which the patient had had for four days prior to admission. He entered the hospital acutely ill with a fever of 104.6 degrees, markedly dehydrated and stuporous. He was started on aureomycin therapy (one gram per day), was clinically much improved in twenty-four hours and felt well and ambulatory within forty-eight hours. He received a total of four grams of aureomycin therapy.

Prior to antibiotic therapy in tularemia, the dictum "31 days of fever, 31 days in bed, and a total duration of disability for about 3.5 months" was prevalent. Of the patients in our series, all of the ulceroglandular, oculoglandular, and glandular tularemia patients were asymptomatic and ready to return to work at time of discharge on an average of twenty days. Of the twelve pneumonia patients, however, average hospitalization was forty days and many had persistent complaints of chronic pulmonary disease, primarily pleural pain, cough, malaise and weakness for many months.

In summary, both streptomycin and aureomycin have been found effective in the treatment of acute infections due to tularemia by decreasing the morbidity, the severity, the complications, and the mortality. Ticks have been the known vector in 65% of these cases. In the ulceroglandular, glandular, and oculoglandular tularemia, we have been using streptomycin 0.25 grams every three hours, for a total of two grams; in the pneumonic tularemia, continuing it until the patient is afebrile. With aureomycin, for the ulceroglandular group four grams is considered an adequate dose which can be administered 250 mg. q.i.d. for four days. In pneumonic tularemia, being treated with aureomycin, the treatment should be continued until the patient is afebrile. Familiarity with tularemia and suspicion are necessary for the early diagnosis and treatment of the pneumonic type. Since two weeks or more are required for laboratory confirmation adequate antibiotic therapy should be instituted immediately if this disease is suspected. This treatment will in no way affect the rise in agglutination titers to interfere with the diagnosis. Apparently, if antibiotics are given early, the patient may be cured before he is able to develop any natural immunity and consequently can be reinfected at a later date.

RANDOM THOUGHTS OF THE SECRETARY

May 28th. In Kansas City where the newspapers comment at length on the fact that today the statute of limitations runs out on the ballot box theft incident to the defeat of a Congressman who failed to merit the favor of a former member of the Kansas City group. Perhaps some of those agents who have been at the AMA office these several months could have been used in the effort to solve this crime.

June 3rd. In twenty-five years of married life most of life's sorrows and cheers come to pass, so thankful indeed is this couple as today we review with customary banter the stirring events of a quarter-century during which we have lived a happy marriage.

June 4th. So long as a few, a very few, are interested in maintaining freedom of initiative and enterprise and in combatting "hand-out" tendencies by governmental means, there remains hope for America.

June 5th. Thanks to Gonzales, the little man with the papers from the College of Surgeons, there is a capacity turnout for tonight's meeting of the staff at Sparks Hospital, an event further discussed in the afterglow out our way.

June 13th. Langston comes to town with lantern slides, documents and rare good humor to discuss medical education in Arkansas, holding his own in a most commendatory manner as the usual queries are voiced, and departs leaving all convinced that good medical education for the benefit of Arkansas is the aim of the authorities.

June 14th. Astounded today in an opaque enema study to observe the progress of the solution on the right and thence to the left, subsequently noting the associated dextrocardia, we cannot contain ourself until we query Chamberlain about this patient of his, the interrogation being somewhat of a backfire since each of us was hoping to catch the other unmindful of the diagnosis, a highly unethical procedure, we allege, on the part of Chamberlain.



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EDITORIAL

ARE DOCTORS CITIZENS?

The wide-spread ramifications of the National Educational Campaign of the American Medical Association has emphasized that physicians can no longer live apart as professional people in a country where the right of active citizenship makes insistent demands for clear thinking and action on the problems of government.

In times like these the citizenship of our country faces its greatest test. Whether the American system of private enterprise and freedom of initiative shall be supplanted by a government responsible for the welfare of its citizens in every detail will be determined in the coming months and in the elections. American freedom may be preserved under our democratic process by votes. Electioneering brings responsibilities. Doctors must assume their full share of the work necessary to elect the candidates in whom they believe. Only by earnest, active effort on the part of citizens will good government continue. In 1950 doctors must enter politics or see politics enter medicine.

Every doctor must exercise his individual right of franchise as a citizens and vote to influence the political direction of our Nation. Failure of the individual citizen, the doctor, to do this may mean the end of the right to practice of medicine according to ethical and scientific standards.

A ONE-SENTENCE EDITORIAL

"A closer study of Mr. Truman's poetic style shows that his technique is never to deal with problems but only with the excellent results that would be achieved if the problems had been solved."—Walter Lippman, commenting on the State of Union message in New York Herald Tribune.

OBITUARY

EARL FERNANDO NORTON, age 59, of Marvell, died May 27th of coronary occlusion. Born in Town Creek, Alabama, he had lived in Marvell for the past 28 years. He graduated from the University of Arkansas School of Medicine in 1918, first practiced at Lake Village and then at Turner prior to locating at Marvell. He was a member of the Phillips County Medical Society, the Marvell Rotary club and of the Methodist church. Surviving relatives are his wife and five sons.

HENRY HASKELL RIGHTOR, age 72 years, died at Helena May 20th after an illness of several months. He was born at McMinville, Tennessee, in 1878, and graduated from Tulane University School of Medicine in 1904. He served an internship at Charity Hospital, New Orleans, and later took special training at Manhattan Eye, Ear, Nose and Throat Hospital, New York and in Vienna. He was most active in civic and medical affairs throughout his professional life, had extensive farming interests and had traveled widely in the United States and foreign countries. Surviving relatives are his wife, two daughters and a son.

CLARENCE NALL BOGART, age 45, Forrest City, died May 24th after an illness of several months. Born August 2, 1904 at Wheatley, Arkansas, he graduated from the University of Tennessee School of Medicine in 1929 and began to practice with his father, the late J. A. Bogart in Forrest City. During World War II he served in the army medical corps and for a time was

stationed in the India-Burma theater. He was a member of the American Legion, the Saint Francis County Medical Society and of the Presbyterian church. He married Miss Dean DuVall in 1938, who, with two sons, survives him.

CHARLES F. COLE, age 81, of Prattsville, died April 21st. Born in Saline county he had practiced in that county for many years. He had served as a member of the quorum court, as a justice of the peace, as chairman of the RFC county commission and was a member of the Grant County Medical Society, the Harmony Baptist church, the Masonic lodge and of the Woodmen of the World. Surviving relatives are his wife and four sons.

FOSTER JARRELL, age 63, died in Hot Springs National Park May 31st after an illness of two months. Born in Calquitt, Louisiana, September 19, 1886, he first engaged in pharmacy at Huttig and later studied medicine at the University of Arkansas School of Medicine and at Tulane University. He began practice at Hot Springs National Park in 1921. He had served as county coroner since 1943. During World War I he served with the army medical corps as a captain. Surviving relatives are two sisters and a brother.

JOHN S. POE, age 40, Little Rock, died May 22nd. He was a graduate of Washington University in 1935 and had served in the army medical corps during World War II. He moved to Little Rock on May 1st to serve as head of the neuropsychiatric department of the University of Arkansas School of Medicine. He was a member of the Pulaski County Medical Society, the American Medical Association, the American Psychoanalytic Association and the American Psychosomatic Society. Surviving relatives are his wife and a son.

JOHN THOMAS MABRY, age 70 years, of Holland, died May 30th of coronary occlusion. Born in the Happy Hollow community, he had been a life-long resident of Faulkner county where he practiced medicine 46 years. A graduate of the University of Arkansas School of Medicine, he had been an active member of the Faulkner County Medical Society. He was a member of the Masonic lodge and of the Methodist church and served as a member of the Faulkner County Selective Service Board during World War II. Surviving relatives are his wife, three sisters and a brother.

PROCEEDINGS OF SOCIETIES

Garland County Medical Society met in Hot Springs on May 9th with the following scientific program: "Quinidine in Heart Disease," Edgar Hull, New Orleans.

The Sebastian County Medical Society was addressed June 13th by W. C. Langston, Little Rock, on "Medical Education in Arkansas."

A conference on obstetrics and gynecology was held at the University of Arkansas School of Medicine June 12th-14th with the following participants: Willis E. Brown, T. Hart Baker, James Barker, Chas. R. Henry, C. G. Sutherland, R. L. Turnbow, D. D. Wallace, E. J. Easley, J. Growdon, I. Meschan and the guest speakers, James H. Ferguson, New Orleans, William C. Kettell, Iowa City, and Seymour Monat, Saint Louis.

The Pulaski County Medical Society was addressed June 5th by William A. Reilly on "The Early Diagnosis of Poliomyelitis.

E. F. Gray, Secretary.

The Association of Tumor Clinic Staff Members in Arkansas met at Fort Smith May 20th for the following program: "Lesions of the Oral Mucosa," John Lamb, Oklahoma City; "Cancer of the Prostate," Carl L. Wilson, Fort Smith; "Steroids and Hormones in Treatment of Cancer," B. B. Wells, Little Rock, and "Radioisotopes in the Treatment of Malignancy," Edward Reinhard, Saint Louis. A social hour with Drs. D. W. Goldstein and Carl L. Wilson, hosts, followed the scientific session. The Association will next meet at El Dorado.

Doctor and Mrs. J. B. Jameson entertained the Ouachita County Medical Society at a delightful dinner at their home in Camden Thursday night, June 1. The following scientific program was presented: "Surgical Relief of Pain," Robert Watson, Little Rock, and "Pain of Circulatory Origin," Dan Autry, Little Rock.

R. B. Robins, Secretary.

The Fifth Councilor District Medical Society met at Magnolia May 25th for the following program: "Chronic Pelvic Pain," Willis E. Brown, Little Rock, and "The Latest Developments in Our Fight Against Socialized Medicine," R. B. Robins, Camden.

Chas. L. Weber, Secretary.

The First Councilor District Medical Society met May 23rd at Blytheville for the following

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program: "The Diagnosis and Treatment of Epilepsy," L. Koenig, Memphis; "Diagnosis of the Hyperthyroid State," F. T. Billings, Nashville; "The Most Common Cancers," Barton McSwain, Nashville; "Radiologic Aspects of Diseases of the Lungs," G. W. Hudson, Nashville, and "Pharmacy and Socialized Medicine," Mr. Herbert Parker, Jonesboro.

J. H. McCurry, Secretary.

A postgraduate symposium on general surgery and the surgical specialties sponsored by the Arkansas Medical Society and the Arkansas Chapter, American Academy of General Practice, was held at the University of Arkansas School of Medicine June 5-7th. Speakers were H. Fay H. Jones, T. D. Brown, J. W. Headstream, R. E. Rowen, Geo. V. Lewis, A. Watson Miller, Jos. F. Shuffield, S. B. Thomson, J. H. Adametz, Robert Watson, M. D. Prickett, E. L. Rushia, J. H. Growdon, W. F. Becker, H. G. Hollenberg, Hoyt R. Allen, D. B. Stough, M. S. Craig, M. Hara, G. O. Dean, C. A. Rosenbaum, J. A. Buchman, Howard Schwander, W. G. Cooper, H. M. Carney and I. Meschan.

The Craighead-Poinsett County Medical Society was addressed June 7th by Drs. Emmett and Vonnie Hall, Memphis, on "Talks and Discussion on Dermatology."

J. H. McCurry, Secretary.

Union County members who head state committees are: Mrs. Fincher, radio, and Mrs. Murphy, program. There were 21 present.

Mrs. James O. Cooper, Secretary.

The Greene-Clay County Medical Auxiliary will act as hostesses for Open House on National Hospital Day, May 12th, at the Methodist Community Hospital in Paragould. Mr. Eugene Lopez, Hospital Administrator at the Community Hospital, will be guest speaker at a meeting of the Auxiliary on May 15th at the home of Mrs. A. D. Garner. He will outline work that the Auxiliary will help to carry on as a Hospital Auxiliary.

The regular May meeting has been postponed due to the District meeting, held in Blytheville on May 17th.

Mrs. A. D. Garner, President.

Mrs. J. Kenneth Thompson opened the regular May meeting of the Sebastian County Auxiliary, then turned the meeting over to the newly appointed president, Mrs. Loten Shippy. The following officers were elected: Vice-President, Mrs. J. Kenneth Thompson; Secretary, Mrs. J. B. Stewart; Treasurer, Mrs. Roy Shirmer.

The next meeting of the Auxiliary will be in September.

Mrs. Ben H. Pride, Secretary.

Mrs. W. N. Peacock, Ashdown, is the newly elected president of the Bowie-Miller County Auxiliary. Mrs. J. B. Kittrell, Texarkana, is publicity chairman.

The Woman's Auxiliary to the Jefferson County Medical Society held its regular monthly luncheon meeting on May 5 at the country home of Mrs. Fred Hames.

Mrs. Howard S. Stern, president, reported on the recent State Annual Session.

Plans for the 4th Councillor District meeting to be held in Pine Bluff on May 25, were announced as follows: At 10 o'clock in the morning, the Auxiliary will sponsor an open meeting for the women of Pine Bluff, at which time Dr. Alton Ochsner of New Orleans will speak on some phase of cancer. In the afternoon, the wives of visiting doctors will be the guests of the Auxiliary at a tea at the home of Mrs. T. J. Cunningham, Jr.

Mrs. Charles W. Reid, Public Relations chairman, announced plans to carry on a radio program during the summer months in cooperation with a local radio station.

Miss Becky Plummer of Pine Bluff was the guest speaker, and addressed the group on the timely subject of "Flower Arrangement."

Mrs. T. J. Cunningham, Jr.
Publicity Secretary.

A cordial invitation is extended to all members of the Woman's Auxiliary to the American Medical Association, their guests and guests of physicians attending the convention of the American Medical Association, San Francisco, June 26th-30th, to participate in all social functions and attend the general sessions of the Auxiliary. Headquarters will be at the Fairmont Hotel. Tickets will be available at the registration desk only. Please register early and obtain your badge and program.

The Pope-Yell County Medical Auxiliary met in the home of Mrs. L. Gardner for a covered dish supepr on Thursday evening. Mrs. Ellis Gardner, Vice-president, presided over the business meeting. Mrs. Earl Hunt and Mrs. Rex Seigel were guests from Clarksville.

The Journal of the Arkansas Medical Society

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R. B. ROBINS, M. D.
Camden
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MEDICAL ETHICS: YOUR OWN COURSE IN THE CURRICULUM

The 1950 Vinsonhaler Lecture delivered under the auspices of the Beta Theta Chapter of Phi Beta Pi, at the University of Arkansas School of Medicine, Little Rock, Arkansas,

May 12, 1950
by

HARDY A. KEMP, M. D.

Director of Graduate Studies, College of Medicine, and Graduate School Affiliated Hospitals, Baylor University, Houston, Texas

Please allow me to thank you as best I can for the honor you have done me in inviting me to deliver the 1950 Vinsonhaler Lecture. Having known Dean Vinsonhaler, and having been so well acquainted with so many of his close personal friends for so many years, I am deeply conscious of what "Vinsonhaler" means to this school and to the great State of Arkansas. Keenly aware as I am of his devoted service to this great cause, and knowing full well of the high regard and deep affection in which he was always held by his colleagues both at home and abroad, and having the natural desire, as all of us do, to emulate the fine qualities of his indomitable spirit—he would not let this Medical School die; he would not let its good name be sullied—I stand reverently before his memory today, knowing more than ever his sincerity of purpose, and thus I am more firmly convinced than ever before that only those who know and love the great State of Arkansas can truly and lastingly serve it. Indeed the good men do lives after them. We see it here in this Medical School today. Is additional proof at all necessary?

Next, I bring you warm fraternal greetings from Baylor University, from the Dean of its College of Medicine, its faculty, and the members of its student body. As Southern medical colleges our destinies are closely intertwined, our ideals are the same, and our problems are much the same because we are of, and for, the South and its people. But it would be less than fair if I did not warn you that our great and good Baptist university has hired a Lutheran football coach from Nebraska, out of the Navy. Beware.

Seriously, when I went to my dean, Dr. Moursund—he was one of Dr. Vinsonhaler's warmest friends—with this invitation and asked him what I should select as a subject, his unhesitating answer was, "Tell them something Dean Vinsonhaler would most like for them to hear. Don't bother them with ACTH, or the thoracic route to abdominal surgery, or isotopes. Do what you can to reflect what he lived for." And so I have chosen as a subject, "Medical Ethics: Your Own Course in the Curriculum."

After twenty-five years of teaching connections with medical colleges, my early feeling that a formal, systematic course in medical ethics is only a futility has now become a deeply seated conviction, if—an underlined if—if such a course is to be begin-all and the end-all of student instruction in that field.

I do not contend that medical ethics (a code for behavior) has no place in the medical curriculum. For one whose high privilege it has been to administer the Oath of Hippocrates to graduating classes in three colleges of medicine, nothing could be more contradictory. On the contrary, it is my contention that medical ethics are, and should become more and more your own course in the medical curriculum, since I am positive that you earnestly seek after the ideals of medicine, and since I am equally positive that one really learns what one deeply seeks to know. I say so because in thirty years of medical schools and medical schooling I have seen the native idealism of medical students repeatedly break through and assert itself without any help on the part of the teaching staff. Remember, Alpha Omega Alpha and your professional fraternities were student-bred and born. None of them was for social purposes primarily, quite the contrary.

Often this student-born enthusiasm has led those in authority—hurriedly, sometimes—to compound a course, or a series of courses, or even a whole department for medical ethics and its heterozygous twin, Medical Economics. I say heterozygous twin since it is impossible for me to believe that the two as they are generally exhibited today could have come from a single zygote. There are indeed outstanding exceptions and

your course here is one. To my way of thinking Doctor Robins is teaching you a goodly share of my course in Public Health as I teach it at Baylor. In any case, the general rule is that no special or systematic provisions are made for formal courses in medical ethics. Instead we usually find a few hours of voluntary lecturing scheduled on what otherwise had been arranged as a free afternoon. In many such instances the time could best be used for rest and recreation.

Thus it would seem that medicine as a profession is extraordinarily reticent about its ethics. This is all the more strange when we consider that medicine was the first profession to formulate its traditions of correct professional behavior into a code and require allegiance to that code. Today almost every profession, every trade has its code of ethics, each and all of them long ante dated by the Oath of Hippocrates. But with all of our veneration of this code of ours, our greatest inspiration should come from the knowledge that it has not stood fixed and rooted as a summary of faith and doctrine, valid for all time. Time and again the spirit of its many clauses has been revised into modern pledges by which we christen the beginnings of your medical careers. To the uninitiated, however, it might still seem that the Oath of Hippocrates—that ancient symbol—is the begin-all and the end-all of medical ethics, even as a course in medical ethics, or even as a Department of Medical Ethics where formalized medical education is concerned, since little else appears to be done about that part of medical education in a formal sort of way.

When anything else is done, it seems, many times, that some devoted person goes to considerable difficulty both to himself, and others, either to teach a course from the tiny pamphlet, "Medical Ethics," as published by the American Medical Association, or he sees to it that this pamphlet is distributed to all members of our graduating classes. With all due respect to all concerned, for years I have contended that this does not get us very far. I am convinced that this itself produces no real or lasting effect. I have collected my own supporting evidence from too many wastebaskets, and hallways, even up to the very last day of your undergraduate work.

But for graduates and for practitioners, the pamphlet, or even a course, it seems to me, is something else again. For just what, after all, are "The Principles of Medical Ethics of the American Medical Association," to use and quote its title correctly?

What is included in this pamphlet?
More important, indeed, what is left out?

Returning to the "Little Red Book" of the American Medical Association, notice that although the Golden Rule is appended as a summary, the code itself gives precedence to questions of etiquette and professional custom over questions of right and wrong. For example, we are adjured to know what is seemly; what is good form; what is convenient for the smooth movement of daily work; what can be counted upon to minimize friction and keep the peace between doctor and doctor, doctor and patient. "Professional Services of Physicians to each other; the Duties of the Physician in Consultation; the Duties of Physicians in Cases of Interference; Social Calls on the Patient of Another Physician; Services to a Patient of Another Physician; Differences between Physicians; Contract Practice"—these are chapter and section headings in this Code. I should think this would arouse wonder as to the presumptuousness of anyone who would question your personal and protesstonal upbringing by offering this as a "course" in good manners to medical students. It seems to me that if the rules of professional etiquette are not known to you after four, three, two years, or one year of medical school, and if otherwise you could not learn these forms of professional custom at a glance, then you will never grasp them, or even receive them even though they are pounded in by some of our best "pounders."

Therefore, although I am somewhat dismayed, I am not surprised to find shoals of these pamphlets lying around on the floor and in odd corners after graduation exercises. I wonder if the effect so produced is not that of a cheapening of this Code of ours, thus making it of low esteem.

But if I deprecate the distribution of this little book and "pray against it as an evil," what of your teachers who scorn to preach ethics "at" you and relegate such teaching to the clergy, to the "up-lifters," and to deans and directors,—who deliver convocation addresses?

Did you ever hear a single one of your teachers say: "Look at me. Imitate me. Profit by my example"?

No, except in purely technical matters.

But feeling a spleen, percussing a dull area, hearing a murmur, I have often heard, and you will hear: "Here, like this. Give me your hand. Do it like this. Let me show you. Now, try it

this way." Never anything else.

How, then, are ethics to be gotten across?

Let me say, first of all, that medical ethics are gotten across, truly. I have seen it, and I can tell you that it is with what amounts to fatherly pride that I have seen my "boys" come to me as freshmen in every sense of that overworked word and very soon metamorphose into physicians whose courtesy to the most unpromising old wrecks of humanity, whose patience with the fretful whimsies of the "chronic," whose faithfulness through tiresome and unprofitable "rounds," whose honesty in confessing failure, whose bravery in facing helplessness, when death only is sure to win in a palpably one-sided conflict—all these —prove to me that ethics have been transmitted, although there was no teaching given, no moral was pointed out, and there was no consciousness of setting an example on the part of those who were the teachers of those men.

As Director of Graduate Work today, I am free to say these things without fear that I am boasting. As such I can and do revel in the glory of all of you. I bask in your reflected light—and I would take all the credit, indeed, if I could. Seriously, however, in my own teaching it is my most earnest prayer that I can do my part as others do in the transmitting of ideals without any consciousness that I am doing anything but minding my own business as a department head, as a professor, and as a coordinator of the work of others. But that, it seems to me, is only half of the picture.

What is the other half?

The other half is yourself. It is up to you to make medical ethics your own course in the curriculum. Others have. You can.

How to do it?

First of all, may I remind you that this faculty regards you as men of worth? May I emphasize that they have considered that you have those desirable traits of character which they feel can be developed to a surpassingly full extent? And I may say to you that there is not a single one of you here today because of the merit or influence of some other person. Thus not one of you started his professional career with the commission of a dishonest act.

Perhaps you did not even realize it, but right then you started your own course in Medical Ethics, and you passed your own first examination in the course, since, and surely I speak for the Admissions Committee, I cannot possibly see how any person can seek to begin a career in medicine, of all professions, by cheating or attempting to cheat his way into medical college.

When I had to deal with admissions, it was difficult for me not to be lastingly resentful when certain ones attempted to impugn my integrity and that of my faculty by making it appear that honesty could be swayed by pressure, and that a medical college, which certainly should be the fountainhead of ideals, could be bought, sold or traded away. Therefore, along with the passing of your own first examinations, take pardonable pride in the fact that your Admissions Committee is immune to caisson disease. They may appear to "walk that way," but I assure you none of them has "the bends."

Next, may I suggest that there should be at the very beginning of your medical course at least one lecture a week throughout your first year, which would introduce you to a study of human relationships as interpreted by an understanding of human behavior. Here, indeed, are the fundamentals of ethics, the building stones for a real and true foundation. Use them all. Use them well, so that you will indeed come to have and to hold a deep and sincere respect for the dignity of the human individual, however mean or low his estate. There, truly, is the cornerstone for your own course in Medical Ethics, your own course in the curriculum.

Then, begin your study of your teachers, and, as a start, begin by considering the contrast between the comfortable security of the academic platform and the relative tumultuousness of the medical college. Allow all due respect, but remember that for several years before coming here, you were accustomed to seeing your classroom teacher in full control of the situation. He was adequate. He was successful. He enjoyed very special advantages. He sat upon a raised platform in a comfortable chair, and very comfortably laid down the law. He told neat little stories, and he questioned neophytes on a subject completely familiar to him.

In the medical college you will find, and you have found, both clinical and preclinical teachers working, more often than not, in a strained position, battling away at the elements of odds and chances for a result not always worth all the effort that went into it. We medical teachers are never in complete control of the situation. Animals—patients, too—are fractious and unreasonable. Humiliatingly often a well-planned demon-

stration falls through. Too often our medicine, our surgery does no good, and failure "stares at us in dumb reproach out of a sickman's eyes." Research is never "done"; it is never completed. There is always that baffling, beckoning, will-o-the-wisp that leads us on, stumblingly, farther and farther into questioning bewilderment—even despair.

What, then, leads the medical man to go on where others give up?

It is the power of wonder, something which underlies ethics, something very much akin to religion—dare we say, it is just that?

In your work to come you will see more often than not, too often, indeed, the wonders of unconscious physiological action. You will see that it is purposeful and accurate beyond anything we know in the domain of our consciousness. Yet, oftentimes, it is pathetically invariable and inevitable in its behavior. It is suave. It is indifferent; even when the result is only torturing pain, and disease has rendered its continuance only a mockery. It is during such times that ethics will call upon you not to be appalled or dismayed by horror and mystery. Your ethics will summon you to convert the power of wonder over to the power of reason and of action, and in such moments you will be able to use your newly developed sharp-sightedness to follow the path to relief, or, at least, to understanding.

But reason and fortitude will not suffice altogether.

Let me take a particularly vivid page from Cabot's writings. You are to note that for years Richard Cabot was considered the most severe, the most unorthodox of the critics of modern medicine. Yet he was a man whose ethics were regarded as exemplary. Those ethics were self-taught, as this plainly should reveal. He writes:

"Another picture comes before me. We are in the crush and turmoil of an out-patient clinic—female medical—where throughout a long morning we try to solve difficult puzzles, to distinguish and identify faint sounds with the stethoscope, to sift and balance contradicting evidence, to cheer downhearted sufferers and to keep our tempers. Human figures, voices, smells weave about over our heads as we stoop down, at our knees when we stand upright, over our shoulders, under our upraised arms. Bells jingle, babies (in the adjoining clinic) squall. And in the midst of this we have to write well-considered judgments into records that others must depend on for guidance, and to make decisions affecting perhaps the whole future life of a patient and a family. Moreover, to anyone who is sensitive to the mood and to the facial expression of those close around him, the faces and tones of the patients are often a greater trial than the physical distractions of sight, sound and odor. On the day that I am recalling it was 12:45 and we had been at it since 9:00 o'clock. My out-patient chief was an elderly man, delicate in health, fastidious, gentle, skeptical of medical wisdom, slow in all the mental and muscular movements for which such a clinic demands swiftness. He had been toiling through his morning's work—just as he always did—patiently, steadily, but without obvious enthusiasm. He was now seated on a three-legged stool, with a towel across his knees, peering through his spectacles at a student's record of a woman patient whom he had examined earlier in the morning and was now to see and to advise before she left.

"She came waddling towards him with a heavy frown. Her expression of blazing scorn was combined with an hereditary and ingrained gloom, expressed in half-closed eyelids and a drooping mouth. It is an expression terribly familiar in out-patient clinics. It says: 'Leave all hope and all good opinion of yourselves, ye who enter here,' and it says it at a moment when that one most needs hope and confidence. But it is also particularly irritating. For it seems to accuse you of neglect, folly and incompetence. If you can face it down with a decent composure and with a brisk and business-like manner it is ordinarily the best you can do.

"I marvelled, then, when I saw the chief look up from his reading and beam at this minatory and demoralized female. His smile had a welcoming warmth when, slightly rising as she approached, he motioned her to a chair, with: 'Sit here, if you please, marm.' It was all in that last and most unexpected word—old-fashioned courtesy, deference, charming modesty. He brought the atmosphere of a summer garden to meet this miasmic fog. The fog did not yield. The woman showed no slightest appreciation of his kindness, no melting of her scorn. But he carried through the interview as he had begun it and still bowed and smiled to her oblivious back as she stumped sullenly away.

"He had no consciousness that anyone was watching him, no desire to teach, and, I fancy, considered himself a failure at the end of that

morning, as he so often described himself in general. But at least one of his assistants learned some ethics that day."

If silent example is not enough for you, if you demand explanation after demonstration, even if this School of Medicine omits the teaching of medical ethics from its curriculum, if you feel you need more formal teaching in medical ethics, and perhaps you do, plan the course yourselves. Call in those from outside the faculty. Call in faculty members. Take occasion to discuss the contrast as you see it between the behavior of your teachers, now in this situation, now in that. Have your fill of discussion of proper and improper techniques in medical competition. Question or defend all you like the matter of rebate in the sale of spectacles, biologicals, and surgical appliances. Let the smoke-filled welkin ring with the pro and con of state medicine, birth control, contract practice, fee splitting, fees from rich patients, and even euthanasia, that ancient and reliable novelty, that dependable stimulant of readers' interest in the news of the day, tricked out afresh each year when politics are dull and there is a dearth of copy.

But with all this, please let my remarks become more than anything else an encouragement to you to continue along the pathway you have already discovered. Surely you have found that one really learns what one deeply seeks to know. Thus, let medical ethics be your own course in the curriculum, remembering that ethics as a written code, even as an oath for allegiance, can be of value only if periodical revision registers an ethical advance, not an ethical retreat. Moreover, such rules are to be used as a brake against our natural tendencies to slip back. At all events, bear in mind that the best sources of medical ethics is the intimate contact with medical men better than yourselves, ourselves, in which by a dialysis of some sort, nobler habits of thought and action seep across from teacher to student, yes, from student to teacher, indeed, from patient to student and teacher, and from colleague to colleague without a word spoken on the subject.

You will find the guiding principle for this in the last line of Tennyson's "Ulysses": "To strive, to seek, to find, and not to yield."

NO APOLOGIA*

J. P. SANDERS, M. D.†
Shreveport

The well trained family doctor need offer no apology for being a general practitioner.

He has certainly been well trained, not only in college and medical school, but with a good interneship and the hard knocks of a general practice.

This makes him one of the well informed of the medical fraternity.

Continuous study, attendance on medical conventions, post-graduate courses, and constant observance of his own individual cases, make him obviously a very well-trained man.

The general practitioner is certainly a specialist in psychosomatic medicine, of which we have heard so much in recent years.

Knowing the family background as he does, the family problems that are continually arising, their economic difficulties, their religious divergencies, their marital conflicts, he is more able than any other man in medicine to know what their problems are and the best way to solve them.

The general practitioner who brings the babies into the world, treats them for their colds, vaccinates them against infectious diseases, treats the family for their diseases and their accidents, certainly has a knowledge of that family's problems more than any other man can get in a short period of family history or in a few visits to his office.

The family physician is also a specialist in public health.

He must know sanitation and preventive medicine.

He knows the requirements for pure food, water and milk, and the requirements for good housing in his particular community.

He is an expert on vaccinations and what diseases the family is to avoid.

He is a consultant on vacations, what exercise the different members of the family should take and what rest periods should be required for those who are ill.

Certainly a man so well trained in all of these

*Presented before the Arkansas Chapter, American Academy of General Practice, Fort Smith, April 16, 1950.

†President-Elect, American Academy of General Practice.

need offer no apology for his knowledge.

Pre-Medical Training

Pre-medical training is the same, of course, whether for general practitioners or for specialists. The student takes the same required courses in the sciences, English and other educational subjects, regardless of what he is to do with his education after he has graduated from medical school. At the present time this is equivalent to a bachelor's degree in most cases.

Medical Education

All medical schools at the present time prepare their students to be doctors. (I am reminded here of an inebriated patient who entered our Charity Hospital in Shreveport one night recently, with a broken shoulder, and when the interne asked him if he wanted a specialist, he said, "Specialist, hell! What I want is a doctor.")

All courses in medical school are taught with the idea in mind of making good doctors.

In general, the medical teaching is so coordinated that whole systems are learned by the student and little attempt is made to break it down into its component parts. For example: Physiology teaches the circulatory system as a whole; similarly with the nervous system, the excretory system, etc. Pharmacology deals with the action of drugs on the different organs of the body. We know that one drug may have a major action on the brain, but it has a minor, and frequently a very important action on the other organs of the body, such as the kidneys, the digestive tract, or the muscular system. The knowledge of this action is important. We would hardly think of teaching eye, ear, nose, and throat by taking out those organs separately, examining them anatomically and microscopically per se, and forgetting the other systems that go along with them. This would indeed be poor teaching. Diseases are rarely taught in connection with one organ alone. All the side effects of that disease on other portions of the body are usually brought in and elaborated upon.

Heart disease, as we well know, not only affects the heart itself, but the blood vessels. Frequently, the kidneys, the liver, the lungs, and many other organs of the body wear out at the same time that the heart wears out. Infectious diseases, though sometimes limited to one organ, always has its side effects on other organs.

Tuberculosis may cause cavities in the lungs, but we always have to watch for infections elsewhere in the body. The intestinal tract, the bones, and even the skin are frequently affected. Pneumonia, a very toxic disease of the lungs, affects every other portion of the body, including the brain and nervous system. Malaria and typhoid fever do not affect one organ alone. Blood stream infections may affect any portion of the body, as we all very well know.

Malignant diseases, such as carcinoma, sarcoma, the leukemias, and other blood diseases, are frequently systemic diseases and not localized to the area in which they originate. Many times it is impossible to determine where the disease starts and where it ends.

All of these examples are brought to your attention for one purpose, and that is to show that no one specialty, except internal medicine, could not cover all this great range of diseases. Yet, it is important for a general practitioner to be able to recognize any and all of them and to be able to diagnose and treat many of them after the diagnosis is made. However, if he feels incompetent to treat any one of them, then it is just as important for him to know the specialist to whom to refer the case. In this way alone will the patient have the best chance for the best care at the earliest possible time. The general practitioner must be just as conscientious in picking out the consultant as he is in making a correct diagnosis.

Post-Graduate Training—The Interneship

Most interneships now are definitely of the rotating type. All of the four major specialties are covered, including surgery, medicine, pediatrics, obstetrics and gynecology, with a smattering of the other specialties thrown in for good measure. We consider this absolutely essential for a well-rounded medical education. In the past, interneships have been attempted on a specialty basis, but these have been found unsatisfactory. The doctors were allowed to go on into their residencies without sufficient grounding in the basic principles of good medicine. Consequently, they were not as good specialists as they should have been. Therefore, most hospitals have returned to the rotating interneship.

Post-Graduate Training—Residencies

The object of residency training now seems to have gone astray from what it was originally intended. Formerly residency training was given purely for the purpose of better qualifying the young doctor to take up the practice of medicine and to give better medical care to the patients. Many times he felt like if he stayed on another year under good supervision, gained a little more

experience, and had a little more practice in the care of patients himself, he would feel more capable of going out into practice and properly caring for patients.

But the trend now seems too much toward meeting "Board Requirements." This is because a young man feels that he is not properly qualified until he has taken his board examination. The dean of one of our medical schools recently told me that on questioning many of the applicants for residency training as to what their purpose was, he received this answer: "To meet board requirements."

An interne who goes on into his specialty without any private practice, is missing one of the important parts of any medical career, and that is "to learn by doing."

Early residency training has its advantages, of course. The doctor is young. He either has no family at all, or his family is small. He can take the time out at this time with little cost to himself or to others. At a later date, he may have to give up a lucrative practice, stand considerable loss of income, and sacrifice his wife and children to another two or three years of hardships. This is frequently hard to do.

The disadvantages include the following:

Many of them do not know whether they want to do a specialty. They do not know what that specialty is, and they have not had the background of general medicine that a private practice would give them.

Certainly there are misfit specialists from too early specialization.

Residencies in general practice should probably be limited to one or two years, not more.

They should cover all the fields of medicine, and should emphasize the particular field in which the young doctor will do the most work.

The young physician who knows he is going into a rural community in which there is a small hospital where he will be called upon to do surgery, would need more surgical training, particularly emergency surgery, than if he were going into a larger community in which there were several surgeons already on the field.

Since he will have to continue his post-graduate education to stay on in our Academy, we think it is better for him to get in practice after one or two years' residency in general practice than to stay on for a longer period of time.

Ostensibly, he never learns it all, but he will continue to learn if he reads, takes post-graduate education every year, and continues to study his own patients.

After he has finished his residency, he should be able to take care of 85 to 90 per cent of all his practice in an ordinary community. He is ready to start making a living and be self-supporting. This, itself, is the thing that he has been working toward for the past ten years. Later on, if he decides to specialize, we think he will make a much better specialist. We also think he should be given considerable credit for his residency training and for his general practice.

Many general practitioners, in the larger communities particularly, will find it easy to gradually limit their practice to their special field of endeavor and later consummate that training in the smallest possible time away from home. In cities with large teaching hospitals specialists are trained in all lines. A man doing general practice in such a city would find it very easy to attach himself to the specialty service of his choice, work there under the supervision of more skilled men, and gradually limit his own practice to the specialty in which he was interested. Then when he was ready to limit his practice, he could probably go away from six months to a year, complete his training, and return home a full-fledged specialist and have a good practice almost from the start. This has already happened many times in areas all over the country.

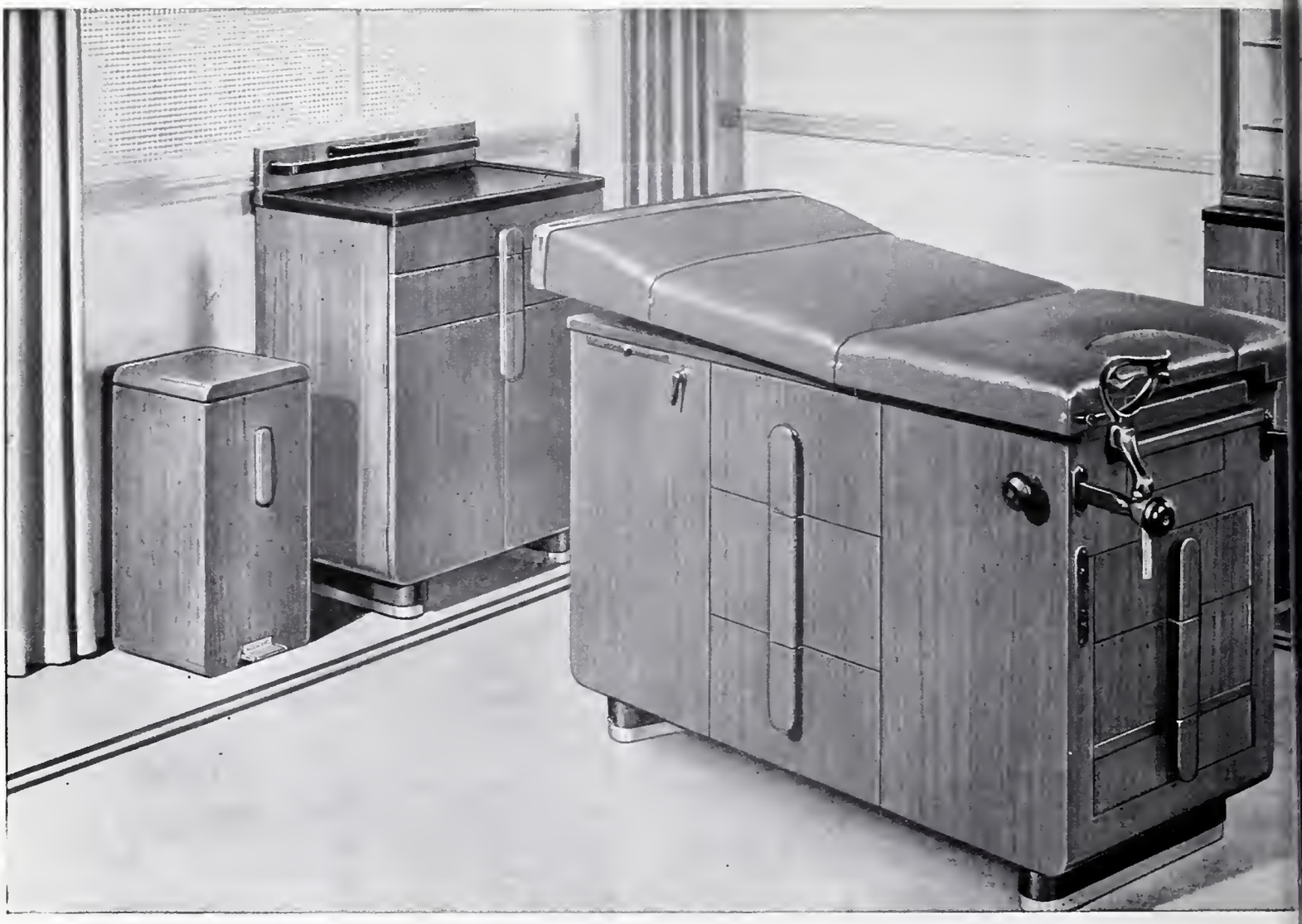
The General Practitioner and the Specialist As a Team

The general practitioner is by nature a family doctor. He knows all the family, their requirements, their diseases and ailments, and their financial status. He should be consulted with every ailment first.

The specialist is trained in his own particular field. He is and should be the consultant.

The general practitioner, when he runs into difficulty with his patient, should always be ready and willing to call in this consultant. The specialist should keep the general practitioner on the case until the patient is well. Then, of course, he should still be the patient of the general practitioner. Each one of this team should recognize the importance of the other in treating each and every disease.

The general practitioner must realize the better training that the specialist has in his own particular field. But the specialist must also realize that he has had little or no training in the other fields in which the general practitioner might be



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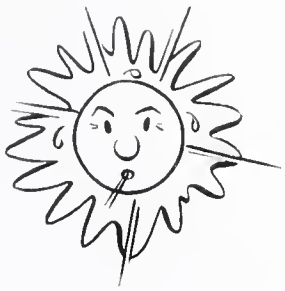
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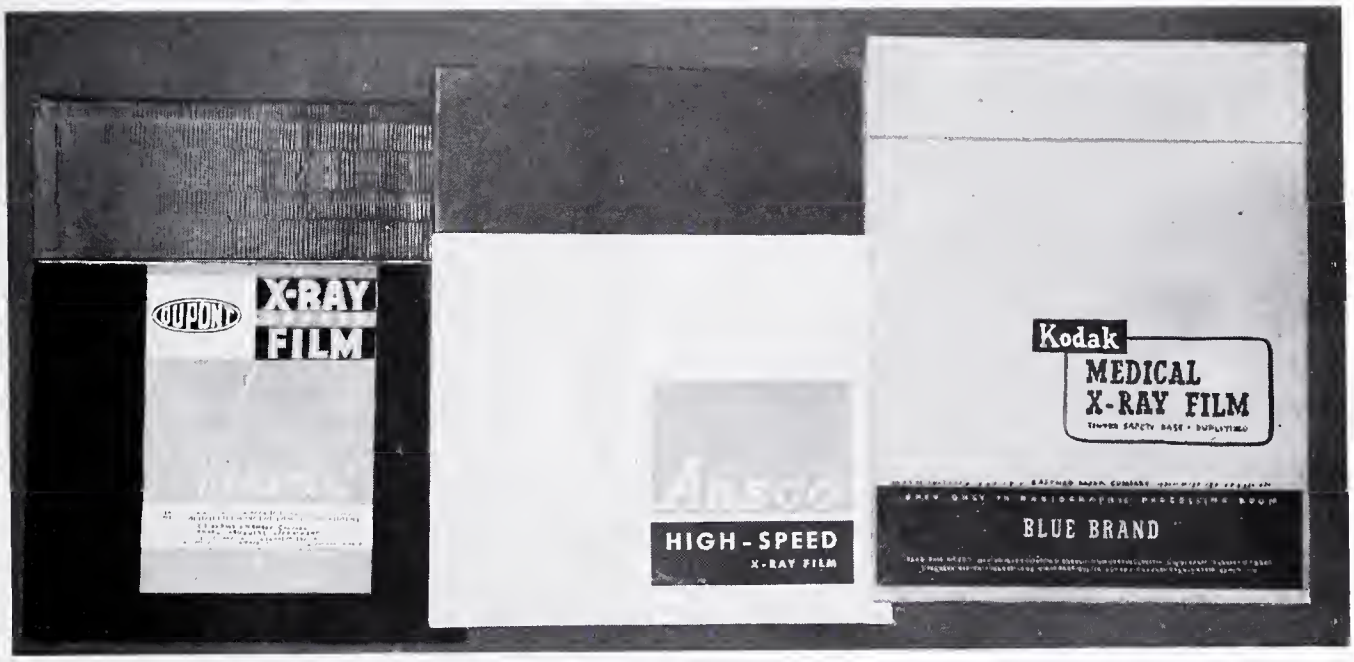
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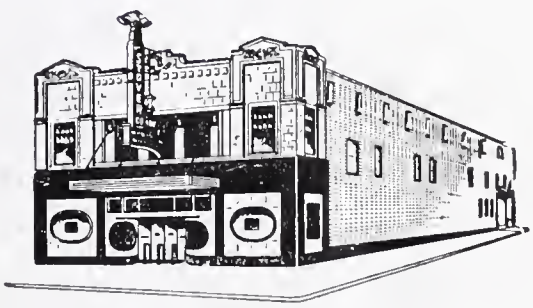
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considerably more proficient. If other specialists are needed, it should be the general practitioner who calls in the other consultant, and not the specialist. Under such an arrangement, the patient gets the best medical care available, and at the least cost to himself.

Since the well-trained general practitioner can take care of a large percent of the illnesses, specialists are often unnecessary. But when the consultant is required, then the family doctor will know whom to consult. For patients to try to pick out their own specialists to start with is many times inadvisable. The specialist may have to call in other consultants because the disease is not in his own line of work. If the general practitioner and the specialist work as a team, then there will be less friction between the two groups and, of course, the patient will be better off.

At the present time we see patients trying to pick out their own specialists, not knowing what disease they have, or whom they should consult. A patient might have a pain in the epigastrium and in turn consult a cardiologist, a gastro-enterologist, a radiologist, and finally find that he had an allergic condition of his stomach. This would certainly be very expensive so far as the patient is concerned, both in money and time, and would probably be obviated if his family physician were consulted first.

The general public has become imbued with the idea of specialization. Frequently they think because a doctor is a specialist that he is sort of a super-medical being, especially endowed with peculiar and unusual abilities. For instance, a surgeon may be the best in his field but knows nothing about children's diseases. Actually he may be at a complete loss in diagnosing a case of diarrhea. Therefore, it becomes essential that the consultant confine his activities to his own specialty in his own field. To attempt to go beyond that field is just as bad as for a general practitioner to go beyond the field in which he is trained.

The specialty boards are probably correct in insisting that their men limit their practice 100 per cent to their own specific field. The colleges, particularly the American College of Surgeons, have never demanded that their fellows limit their practice to their field. If a specialist expects to do a full-time specialty, then he will not keep up with the other fields of general practice and therefore, sooner or later, becomes untrained in those fields, and will not be as thorough as a general practitioner who has kept up his training.

If we remove the glamor from specialization, give the general practitioner more prestige, permit his income to be commensurate with that of the specialist, then we will find many more of our young graduates entering the general practice of medicine.

Many young men have gotten the idea during their medical course that specialization is absolutely essential. I had a junior medical student in one of our medical schools of this country tell me last spring that one of his professors had told the class that in another three or four years there would be no such thing as a general practitioner left. This boy was very much interested in going on into general practice back in his home town, and certainly wanted to be well trained in all the fields of medicine so that he could do a good job back home.

There should be no rivalry between the specialist and the general practitioner. If each will stay within his own realm of endeavor and both work as a team, a great many of the unfair practices will be eliminated. General practitioners will not hesitate to call in a consultant if he is assured that that consultant will not take the patient. Too many times when a general practitioner calls in a consultant, the specialist takes over the patient and the general practitioner never sees him again. This has the effect many times of causing the general practitioner to fail to call in consultation when it is really needed. The general practitioner should always stay on the case until it is completed.

A specialist should limit his practice to his specialty. But if he does general practice, let him call himself a general practitioner and not a specialist.

What Is a Well-Trained General Practitioner?

A general practitioner is usually defined as "a doctor that does not limit his practice."

If he is well trained, then he certainly keeps up with all the latest developments in medicine by whatever means is possible. He keeps up his post-graduate training, his medical society meetings, and takes post-graduate courses. A man who wants to treat all the human ills, certainly in present-day medicine, has to keep up with many advances in medicine. He must be a great student and do constant study. Actually he must know more medicine in all its various ramifications than any other medical man. A specialist friend of mine in Shreveport recently told me that he did not know enough to be a good general practitioner. A general practitioner must be

a student of current events, past history, and present-day happenings on the national and international scene.

Of necessity, the general practitioner must love and understand people. He must develop a wide experience outside the actual practice of medicine. He must have a great tolerance for people's ideas and differences of opinion. He must have a compassion for being useful and for serving in the time of need. This is what has made the medical profession great. The general practitioner needs it as much as ever before.

There is no man in medicine that must know more about the art of medicine than the general practitioner. It is somewhat of a forgotten art in today's age of specialization.

Many of the specialists find the art of medicine unnecessary in their particular line. A surgeon can take out a gallbladder as well whether the patient likes him or not. A pathologist can determine just as well if a specimen is cancerous whether he has seen the patient or not. A radiologist can read an X-ray film without trying to prove to the patient that he is a good doctor.

Some of our greatest specialists have the poorest personalities of medical men. But this is not true of the general practitioner. To be successful, he has to have an outstanding personality. He must make friends easily, and keep them. In order to instill confidence into his patients, he must be sincere. In order to size up difficult situations, he frequently has to make up his mind quickly and must be right in those decisions. He must not be arbitrary, but must be willing to give and take for the common good of the patient. To be a good general practitioner, he must be an artisan as well as a scientist.

Conclusions

In conclusion, I wish to state that the general practitioner must of necessity be as well trained as his specialist confrere.

Since he does as much work for the patient, comes closer to the family than most specialists, and all in all, does as much good as any other man in medicine, he must be well qualified to be a good general practitioner.

But if he has all these qualities, then there should be no apology either from the physician himself or from the patients for his being a family physician.

He should enjoy the same rights, the same prestige, and the same compensation as his professional brother, the specialist.

JAMES M. NORTON, age 64, of Arkadelphia, died June 16th after an illness of eleven months. Born near Malvern, he graduated from the College of Physicians and Surgeons, Little Rock, in 1911 and began practice at Cedar Point, later moving to Donaldson, and following two years at the State Hospital, located at Arkadelphia. He was a member of the Clark County Medical Society, the Arkansas Medical Society, the Masonic lodge and the Baptist church. Surviving relatives are his wife, two daughters and a son.

FOUNDATION OFFERS FELLOWSHIPS

The Arthritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from $4,000 to $6,000, depending upon the needs and ability of the worker, and run for a period of one year. The fellowships would begin in July 1951, although earlier appointments would be considered by the committee.

The Foundation is anxious to back a candidate, rather than a project, an institution, or a hospital. It hopes to arouse interest in arthritis in a wider circle of medical investigators and to encourage able, inquiring minds.

Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York, by January 1, 1951. Notification of the fellowships granted will be made March 1, 1951.

If any applications are received by September 15, 1950, they will be acted on at that time and notification made immediately.



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EDITORIAL

ROBINS ELECTED VICE-PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION

At the San Francisco session, the House of Delegates elected Dr. R. B. Robins, Camden, to the Vice-presidency of the American Medical Association for the year 1950-1951. The honor of becoming Arkansas' first general officer of the national organization is justly deserved. In the past year Dr. Robins has made over twenty major addresses to civic and professional groups on socialistic trends in government. He has written a number of articles on the same subject which have had national circulation. He has been unstinting in time and effort, indefatigable in advancing the cause of the private practice of medicine as opposed to governmental planning and regimentation. The national organization will profit by his enthusiasm and guidance in the year ahead.

INAUGURAL ADDRESS DR. ELMER L. HENDERSON

In a hard-hitting inaugural address here tonight, broadcast coast-to-coast over two radio networks (ABC and Mutual), Dr. Elmer L. Henderson of Louisville, Kentucky, new president of the American Medical Association, charged that "the administrative arm of our Government has failed us in this generation."

The fighting doctor from Kentucky, who took his oath of office at an open meeting of the A.M.A. House of Delegates, and whose message was heard by millions of the American people, flatly accused "little men with a lust for power" in the executive branch of the Government of seeking to make America "a Socialist State in the pathetic pattern of the socially and economically-bankrupt nations of Europe."

A Sick Government

The Administration in Washington, asserted Dr. Henderson, is "sick with intellectual dishonesty, with avarice, with moral laxity and with reckless excesses."

That condition must be changed, he declared, "if we are to survive as a strong, free people"—and he called upon all of the American people to share the responsibility and to uphold the nation's ideals of freedom.

To the 144,500 members of the A.M.A., who had received special invitations to hear their new president's address, he said:

Medicine—the Target of Cynical Men

"Tonight I call upon every doctor in the United States, no matter how heavy the burdens of his practice may be, to dedicate himself, not only to the protection of the people's physical health, but also to the protection of our American way of life, which is the foundation of our economic health and our political freedom."

Continued the new A.M.A. president:

"American medicine has become the blazing focal point in a fundamental struggle which may determine whether America remains free, or whether we are to become a Socialist State, under the yoke of a Government bureaucracy dominated by selfish, cynical men who believe the American people are no longer competent to care for themselves.

Under Socialism, Liberty Dies!

"These men of little faith in the American people propose to place all our people, doctors and patients alike, under a shabby, Government-dictated medical system which they call Compulsory Health Insurance. But it is not just socialized medicine which they seek. Their real objective is to gain control over all fields of human endeavor—and to strip the American people of self-determination and self-government.

"There is only one essential difference between Socialism and Communism. Under State Social-

ism human liberty and human dignity die a little more slowly, but they die just as surely."

Then Dr. Henderson, declaring that "American medicine has led the world in medical advances, and has helped to make this the healthiest, strongest nation on the face of the globe," blasted the critics of medicine with this significant statement:

"It is not American medicine which has failed to measure up to its obligations.

"It is not American business nor American agriculture which has failed—nor the fine, loyal working people of America who have failed.

"It is the administrative arm of our Government in Washington which has failed us in this generation!"

Press Praised for Leadership

Stressing the fact that many already recognize the dangerous trend toward concentration of power in Washington, Dr. Henderson declared:

"If it were not for the leadership of the American press, in defending our fundamental liberties, American medicine, even now, might be socialized—and under the heel of political dictation.

"The newspapers of America, with few exceptions, have taken a strong stand, not only against socialized medicine, but against all forms of State Socialism in this country—and the doctors of America are proud to take their stand beside the fighting editors of America in the battle to save our freedom and the system of individual initiative which maintains it."

The Miracle of Medical Progress

Reviewing the great achievements of American medicine at the halfway mark of the 20th Century—with 19 years added to the life span during the past five decades, with many dreaded diseases conquered, which were leading killers at the turn of the century, and with the maternal death rate in this country now lower than in any other nation—the A.M.A. president commented:

"The story of never-ending medical progress in this country is not just a story of so-called miracle drugs and miracle discoveries. The real miracle of American medical progress is the miracle of America itself—the motivating power of the American spirit, of free men, unshackled, with freedom to think, to create, to cross new frontiers.

"This is the spirit, and these are the very methods, which Government domination of medical practice would destroy."

Voluntary Way Is American Way

Declaring that the nation's medical care problems can be resolved "without compulsory payroll taxes and without political pressure," Dr. Henderson pointed out that approximately half the population of the country already has enrolled in Voluntary Health Insurance plans "to take the economic shock out of illness."

Said Dr. Henderson:

"Within the next three years, in the opinion of leading medical economists, 90 million persons will be enrolled in the voluntary prepaid medical plans—and when that number has been reached, the problem will have been largely resolved."

Dr. Henderson concluded his address by thanking the American people for coming to medicine's defense when it was brought under attack—and reported that more than 10,000 national, state and local organizations, with many millions of members, have taken positive action against compulsory health insurance.

EDITORIAL COMMENT

CHRISTIAN MEDICAL RESEARCH LEAGUE

Should any member be interested in attending the sessions of the above organization, he is advised to obtain information from headquarters office.

BOOK REVIEW

Diseases of the Heart, by Charles K. Friedberg, M. D., Associate Physician Mt. Sinai Hospital, New York; Lecturer in Medicine, Columbia University. 1,081 pages with 79 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $11.50.

This is an excellent treatise on the heart fully and well-illustrated, readable, with complete discussion of the many phases of the subject.

The Merck Manual. Cloth. Eighth edition. Pp. 1,592. Price $5.00 with thumb index. Rahway, N. J.: Merck and Company, 1950.

This new and revised manual is current on medical subjects to May 1, 1950. Diagnosis and treatment of disease are given primary importance; over 1,000 prescriptions are given, calling, in the most part, for official or semi-official drugs. Laboratory tests, pre- and post-operative care, diets and other data are included in the second section. This is a handy and most concise source of medical information for the busy physician.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

SOME mental reservations seem to exist, both here and in England, as to the value of mass surveys for the detection of tuberculosis in the light of the long waiting lists of patients with positive sputum. While complacency about infectious tuberculosis is shocking, yet there is great virtue in knowing the extent of the problem. The average citizen who finds that he has positive sputum is willing and ready to protect his contacts and to limit his own regimen for the betterment of his health.

A CRITICAL EVALUATION OF MASS ROENTGEN SURVEYS

Mass surveys, however, must not be viewed as the mere taking of pictures if they are to be effective in controlling tuberculosis and in uncovering pulmonary neoplasms. It must be recognized that more is needed than physical equipment, a technician, and a physician-reader. A definite philosophy is required. Because of the infectiousness of pulmonary tuberculosis and the seriousness of broncho-genic carcinoma, all photofluorograms which reveal any characteristics of either should be read as "suspect tuberculosis" and/or "suspect neoplasm."

Thus, a significant percentage of patients whose photofluorograms were read as "possible tuberculosis" should ultimately be proved nontuberculous. For instance, an area of rarefaction should be interpreted as probably advanced tuberculosis although later it is lung abscess. However, no photofluorogram read as nontuberculous basal infiltration should be found to represent active basal tuberculosis.

Similarly, when a solitary mass, atelectasis, emphysema suggesting obstruction, mediastinal enlargement, soft infiltration or cavity associated with mediastinal shift is found, the survey film should be classified as "suspect neoplasm," especially in middle-aged men. Neither film reader nor clinician should be disturbed if these lesions are subsequently found to be relatively innocuous. If bronchogenic carcinoma is ever to be conquered, it must be suspected earlier and handled as a medical emergency. Any persistent pulmonary infiltration not definitely diagnosed as tuberculous should be considered potentially malignant just as it is wise to consider all pleural effusions tuberculous until proved otherwise.

Another important aspect of survey work is the population segment to be studied. Only 0.3 per cent of 4,059 Philadelphia primary school children surveyed in 1946 were possibly tuberculous. In contrast, 8.4 per cent of 3,106 diabetic patients surveyed in 1946 and 2.3 per cent of 32,535 foodhandlers surveyed in 1947 showed possible tuberculosis. In 1948, 2.5 per cent of 20,903 Philadelphia industrial workers had a survey reading of possible tuberculosis while, for Philadelphia General Hospital admissions and out-patients, the percentage was much higher, 6.4 per cent.

It has been emphasized that only apparently healthy persons are suitable candidates for surveys. While this attitude is based on the sound premise that persons with signs or symptoms deserve more careful study than a single miniature film, the fact remains that innumerable persons with symptoms do come to survey units for photofluorograms. Many physicians hesitate to refer patients who have respiratory symptoms for careful radiologic study because of expense.

If this situation is recognized, a properly indoctrinated survey staff can surmount the obstacles presented by these persons and their physicians by inquiring about presence of cough, chest pain, and blood spitting as the film is taken. Frequently this elicits voluntary information about other pulmonary symptoms. These data can be noted on the card so that the physician reading the photofluorograms can add to his "negative" report to the referring physician some such phrase as, "May we call attention to the fact that one miniature photofluorogram does not constitute adequate study in the presence of signs or symptoms." If such persons have no private physician, an explanation can be made of the

importance of more careful studies and suitable referral made.

There are even a number of ex-sanatorium patients who have not returned to clinics or physicians for years but who come to surveys. These persons should be interviewed, impressed with the wisdom of periodic check-up and referred to a physician or chest clinic. This is a service the survey unit can undertake. The relapse rate in tuberculosis continues to be about 50 per cent.

Once the readings have been made, prompt interview of the patients with suspected disease is essential. Even an intelligent person may not go promptly to a hospital or chest specialist if the suggestion is made weeks after the taking of the photofluorogram. If a film appears to be of grave significance, the patient should be sent for at once and, if possible, hospitalized immediately. This means personal effort on the part of the survey physician. Such major decisions and vigorous action cannot be taken by clerks nor even by public health nurses. The interview with the patient whose photofluorogram is considered significant should be made by a physician who can explain the photofluorogram to the patient and answer questions authoritatively.

The interview must be conducted with the greatest consideration. To avoid prolonged anxiety, the appointment letter should arrive the day before the interview and should state only that the physician has set the date "to talk over the X-ray." It requires considerable experience to gauge the approach which will impress persons sufficiently to induce immediate appropriate action without disproportionate anxiety.

In the early days of the program when patients were referred to their physicians after the interview with the statement that the physician would receive a report, about 20 per cent failed to report. By the simple expedient of handing them a note on which is written their name, the name of the physician or clinic to which they are to go, the date and a brief, carefully worded report of survey findings, almost 100 per cent response was obtained. Like children, with a paper in hand to be delivered, they had some compulsion to complete the job.

Surveys are merely gestures unless adequate follow-up is an integral part of the survey program. Theoretically, once the person reaches the physician or clinic, the survey task has been completed. Some clinicians, however, fail to study survey cases adequately. Standards for follow-up examination of survey patients should include at least the taking of serial films and sputum studies, including culture. If sputum is not available and the possibility of activity is real, cultures of the gastric washings should be made. Facilities for tuberculin testing should be available.

It is the responsibility of the survey team to check on follow-up for the sake of the patient, the protection of the community, the education of the physician, and the perfection of the survey reader.

Annual roentgenograms of the chest for all adults is a feasible goal. Because bronchogenic carcinoma is found too rarely in a curable stage, it is urged that men over 45 be surveyed every six months.

A Critical Evaluation of Mass Roentgen Surveys, Katharine R. Boucot, M. D., and David A. Cooper, M. D., Philadelphia, J.A.M.A., April 22, 1950.

RANDOM THOUGHTS OF THE SECRETARY

June 24th. Across Kansas to deplane in Denver where the summer weather is a hot 93; revisiting the Ship's Tavern where Boyd entertained the Western States Conference in good anecdotal style; and thence across the "range," observing Boulder for the first time from the air; across Great Salt Lake, desolate Nevada, Oakland Bay and belatedly into San Francisco to locate ourselves for the activities of the coming week.

June 25th. Sitting in with the radiologists at the Mark all this day, afforded a short opportunity to visit the "Top" with King from Memphis and Spike Virden and then to the dinner where it is our great joy to announce and present fellowship in the College to Ed Gray and with the Grays to the Palace's "Happy Valley" where the talk is of youngsters and of many other things.

June 26th. Convening with the House of Delegates, Charles Henry, the interested observer, the talk being of the vice-presidency which has suddenly assumed a commanding importance and competition appears for the post. Tonight to the superbly staged San Francisco County Medical Society banquet which confirms most of the greatness with which Californians are wont to attach to their accomplishments and we doff our hat in sheer admiration to them this evening for hospitality, good cheer and excellent food.

June 27th. With methodical attention the reference committees pore their assigned problems today and, having some free time, to boat ride with Henry and the Wrightsmans about the bay; to lunch in the magnificent California manner of food and proper wine at Bernsteins with Henry and tonight with Amis to that incomparable spectacle, the "Ice Follies."

June 28th. This morning we host the Arkansas breakfast one day in advance, this inattention to detail bringing the Grays, Hoge, the Murrys and Henry as our guests. For lunch to the Bohemian atmosphere of "The Shadows" atop famed Telegraph Hill and back to the sessions of the House where item after item is presented and thoughtfully considered. Once again there is thunder in the East and geography is probably about to be rewritten. Brace yourself: there's rough going ahead!

June 29th. The morning in conference; the afternoon in the House, and elated to nominate Bob for vice-president with no opposition forthcoming. * * * So away from the convention city not having stepped inside the auditorium during all of these days because of need for the work of the House.

June 30th. Departing Los Angeles where the night was

PROCEEDINGS OF SOCIETIES

The Lawrence County Medical Society was addressed at its June meeting by James Growdon and Reuben Zeuker, Little Rock.

Chas. D. Tibbels, Secretary.

The Pope-Yell County Medical Auxiliary held its monthly meeting Friday evening, May 12, in the home of Mrs. W. O. Young, with nine members present. A covered dish supper was served. Mrs. A. Watson Miller, President, presided over the business meeting. A discussion of new projects for the year and plans for the observance of Hospital Day were made. Mrs. Roy S. Millard, Past President, gave a report on the state meeting of the Auxiliary in Fort Smith.

Mrs. W. O. Young.

PERSONALS AND NEWS ITEMS

Dr. and Mrs. Virgil Payne, Pine Bluff, spent a recent vacation in California.

"Strangulated Inguinal Hernia in a Four-Week-Old Infant, with Resection and Recovery," by Howard S. Stern, Pine Bluff, and James E. Jones, Little Rock, appeared in the March, 1950, issue of The American Journal of Surgery.

"The Months Ahead" by R. B. Robins, Camden, presented at the 139th Annual Meeting of the Rhode Island Medical Society, Providence, May 10th, appeared in the Rhode Island Medical Journal for June, 1950.

"Conclusive Fractures of the Dorsal Spine Following Electric-Shock Therapy" by Isadore Meschan, Joe B. Scruggs, Jr., and Joseph D. Calhoun, Little Rock, appears in Radiology for February, 1950.

Mac McLendon has been elected medicin of Marianna voiture, Forty and Eight.

Art B. Martin, Fort Smith, hsa been elected president of the Arkansas Tech Alumni Association.

R. B. Robins, Camden, was elected Vice-president of the American Medical Association at the San Francisco session.

Sam Phillips, Little Rock, took special work in rheumatic heart disease of children at Saint Frances Sanatorium, New York, during June.

Dr. and Mrs. C. A. Archer, DeQueen, and Dr. and Mrs. C. A. Archer, Jr., Conway, spent a recent vacation at Hot Springs National Park and Dr. and Mrs. C. A. Archer, Jr., spent an additional vacation in New Orleans.

W. R. Brooksher has moved into new offices at 100 North Sixteenth Street, Fort Smith.

Dr. and Mrs. J. B. Stewart, Fort Smith, spent a recent vacation at Lake Hamilton.

The following were registered at the San Francisco session of the American Medical Association: J. W. Amis, Fort Smith; J. R. Barnett, Arkadelphia; W. R. Brooksher, Fort Smith; Martha M. Brown, Little Rock; Willis E. Brown, Little Rock; G. E. Cannon, Hope; F. Walter Carruthers, Little Rock; R. E. Crigler, Fort Smith; Fred F. Ferguson, Nashville; W. A. Fowler, Fayetteville; Edwin F. Gray, Little Rock; G. L. Kimball, DeQueen; A. F. Hoge, Fort Smith; M. Charlotte Holmes, Hot Springs National Park; F. H. Jones, Piggott; L. K. Hundley, Pine Bluff; C. Lewis Hyatt, Monticello; Fred H. Krock, Fort Smith; W. C. Langston, Little Rock; H. E. Murry, Texarkana; Norman Peacock, Ashdown; W. A. Reilly, Little Rock; Cecil Riggall, Prairie Grove; R. B. Robins, Camden; E. Driver Rowland, Hot Springs National Park, and J. A. Summers, Little Rock.

An "Institute of the Nursing Care of the Poliomyelitis Patient" was held at Fort Smith July 17-18th with the following speakers: "Epidemiology, Pathology and Preventive Measures" and "Diagnosis," Ken Thompson; "Medical Care During Acute Stage (including bulbar and respiratory involvement)," Pearl Waddell and F. E. Shearer;

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muggy and humid, most unpleasant after the cool weather at San Francisco, to step forth for a day at Tucson where it is but 105!

July 1st. A short stay in El Paso; dinner in Shreveport; then a change of travel plans in order that we may visit Peggy in Little Rock and exchange experiences of the past ten days.

July 2nd. For the first time in our professional career, we move, fortunately during our absence, and now busy in locating various papers and equipment. Delighted with the new place where there is room to rattle but mostly the pleasure of parking at the door side and not waiting for the elevator.

July 4th. Driving to Little Rock for a date with the wife, dining and dancing (once) at Tia Wanna and a good time was had by all.

July 5th. Up betimes for the return trip homeward, to breakfast at Booneville at seven which shakes off some of the sleepiness and on in to the work of the day.

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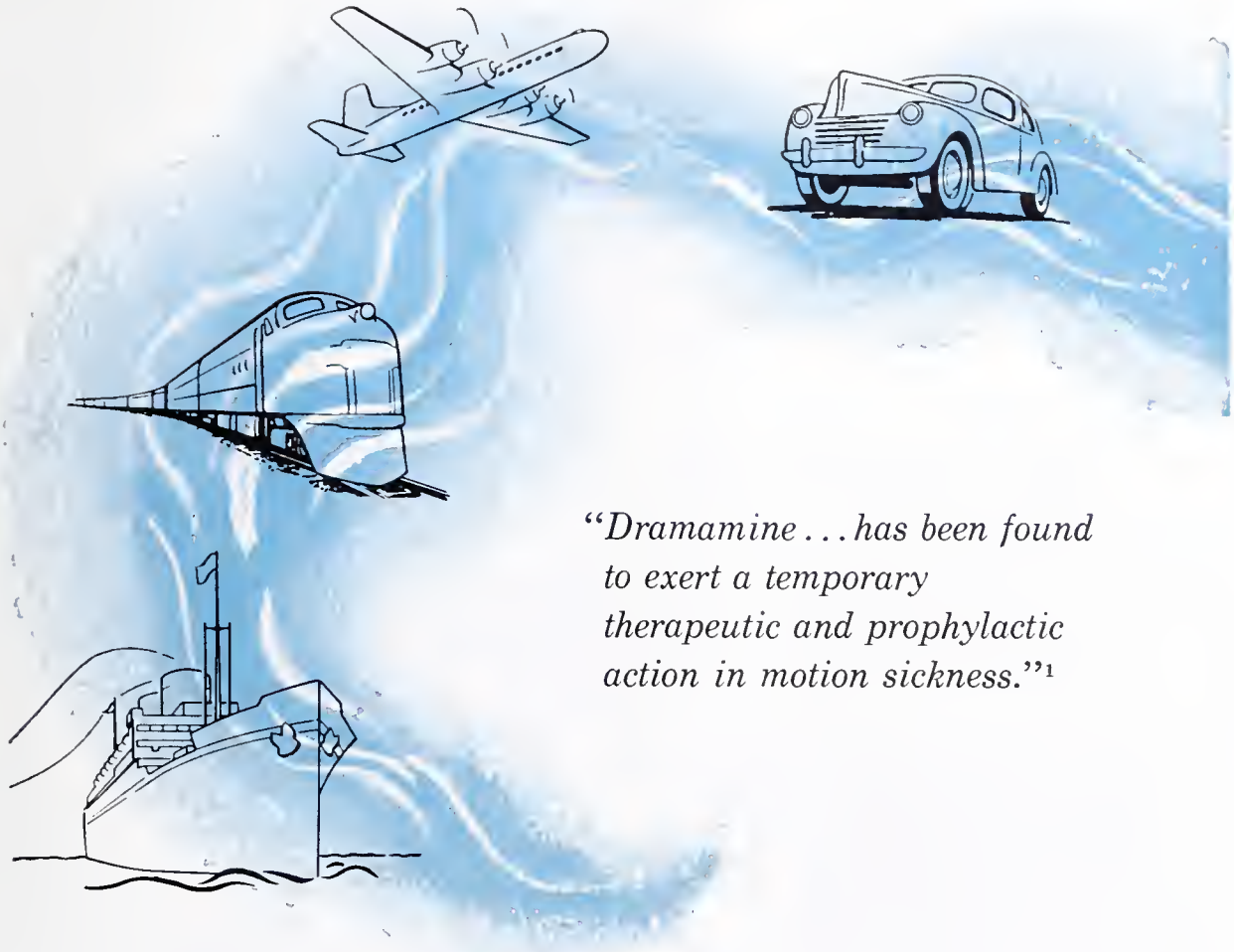
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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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1. Council on Pharmacy & Chemistry: New and Non-official Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

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"Review of Anatomy," T. P. Foltz; "Tracheotomy, Laryngoscopy and Bronchoscopy," Chas. S. Lane, Jr.; "Role of the Physical Therapist," A. S. J. Clarke, and "Medical Care During Convalescent Reconstructive Period and Residual Stage," W. E. Knight.

H. H. Holt has been elected surgeon of the Nashville post, American Legion.

"Tantalum Gauze Repair of Incisional Hernia" by Howard S. Stern, Pine Bluff, appeared in The Journal of the International College of Surgeons, April, 1950.

Hoyt R. Allen, Little Rock, has been elected president of the American Proctologic Society.

Among those driving to the San Francisco session of the American Medical Association were Dr. and Mrs. Fred H. Krock, Fort Smith; Dr. and Mrs. L. K. Hundley, Pine Bluff, and Dr. and Mrs. Ed Gray, Little Rock.

W. H. Gibson, Ozark, has been elected a director of the Junior Chamber of Commerce.

Joe Rushton has been elected president of the Magnolia Rotary Club.

G. C. Regnier has been appointed chief of radiology, Veterans Hospital, North Little Rock.

L. P. Moore is now associated with Raymond Cook in the practice of ophthalmology at Little Rock.

Louis K. Hundley, Pine Bluff, was recently elected vice-president of the Pine Bluff Rotary Club.

WOMAN'S AUXILIARY NEWS

The Independence County Medical Auxiliary met June 12th at the home of our president, Mrs. C. G. Hinkle, for a call meeting.

The purpose of the meeting was to acquaint the members with the work set out by our State President, Mrs. Warren S. Riley. The Credit Sheet was primarily discussed and all agreed to try our best to fulfill the requirements set out. Legislation was also in the spotlight and tentative plans were made to acquire some time on our new radio station, which will be in operation soon. The Speaker's Bureau consists of three members, namely: Mrs. J. J. Monfort, Mrs. L. T. Evans and Mrs. C. A. Churchill.

The next meeting we will join the Society at the home of Dr. Ruth Junkin for a picnic.

Mrs. Chas. Taylor, Publicity Chairman.

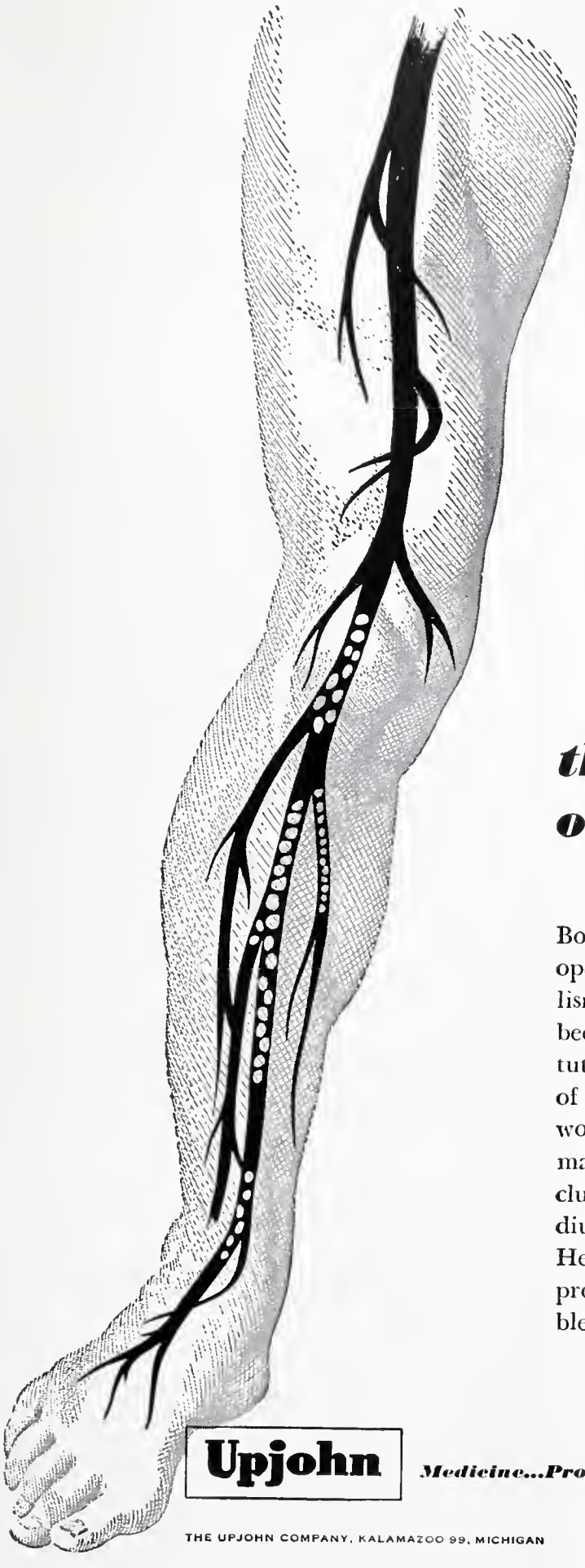
The Greene-Clay County Medical Auxiliary met with the Doctors on June 14th for dinner in the Hospital dining room. The speakers for the evening were Dr. Ellery Gay, who gave a paper on "Burns," and Dr. Joe Shuffield, who talked on "Fractures of the Hands."

The Auxiliary met June 22nd with the Hospital Superintendent and made plans for the new polio ward in the Community Methodist Hospital. The Auxiliary plans to make all packs, pads or anything needed in the care and treatment of polio patients.

Mrs. A. D. Garner, President.

The annual spring meeting of the Auxiliary to the Ninth Councillor District Medical Society was held at Mountain Home May 15th at the Decar Grill in a luncheon meeting with members of the Ninth District Medical Society. Mrs. H. V. Kirby, Auxiliary president, and Dr. B. N. Saltzman, president of the medical society, presided. Following the luncheon, Auxiliary members were entertained with a tour of Norfork Dam by Mrs. B. N. Saltzman, followed with a business meeting and program at the Norfork Dam guest house. Reports of the state convention held in Fort Smith were given by Mrs. J. G. Gladden, Mrs. O. B. McCoy and Mrs. W. H. Breit. Mrs. Ross Fowler spoke on "Arkansas Efforts to Combat the Trend Toward Socialized Medicine." Out-of-town guests included Dr. Edgar Hull, Louisiana State University School of Medicine; Mrs. Edgar Hull, Dr. Robert Watson, and Dr. Eugene Crawley of Little Rock, and Dr. W. R. Brooksher and Mr. Sid Wrightsman of Fort Smith.

The Garland County Medical Auxiliary met at the home of Mrs. Euclid Smith, May 15th, with Mrs. Leeman King, Mrs. Clay Chennault and Mrs. Turner Wootton as co-hostesses. Mrs. C. Travis Drennen of Aplachecola, Fla., was a very special guest. She organized the first Garland County Medical Auxiliary in her home approximately twenty-five years ago. She was the first president of this Auxiliary and the third Arkansas State Medical Auxiliary president and has always been a most active worker in the Medical Auxiliary. She gave an interesting talk on the history of the organization, its problems and achievements and complimented the present Auxiliary on their plans for the new year, and how they were carrying out the ideas that the first Auxil-



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iary had hoped to achieve. Mrs. Leeman King, president, presided over a short business meeting and turned the meeting over to the new president, Mrs. John Dodson, who outlined her program for the new year. Plans were made for a Speaker's Bureau, Radio Program, Year Book, and a tea to be given for the Convention of State Nurses, September 15th. Mrs. Dodson appointed all the committee chairmen.

Mrs. L. E. Reed, Publicity Chairman.

The Auxiliary to the Washington County Medical Society met May 17th at the home of Mrs. G. H. Butler with eleven members present. Committee chairmen were appointed for the new year by the president, Mrs. J. R. Stocker.

A report on the state convention was given by Mrs. Fount Richardson and Mrs. Max McAlister.

Mrs. G. H. Butler.

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CATARRHAL OTITIS MEDIA WITH EFFUSION*

PAUL L. MAHONEY, M.D. and A. J. BRIZZOLARA, M.D.
Little Rock

The title of this paper is self-explanatory, the etiology is not singular, the symptoms are fairly constant and annoying, the diagnosis is not too difficult, the treatment is rather simple and practically devoid of complications. The results are striking and dramatic, in most cases, and very gratifying to the patient.

Years ago we recognized these pathological changes in the middle ear, felt the cause was the result of closure of the mouth of the Eustachian tube, made every effort to reverse the inflammatory changes in the mucous membrane, and too often without success. We insufflated various vapors into the Eustachian tube, introduced minute applicators wrapped with a few fibres of cotton and saturated with varying strengths of silver nitrate through an Eustachian catheter into the tube, used suction through the catheter and with positive pressure we forced solutions to produce vasomotor constriction of the vessels in the mucous membrane. All too often without success.

What I am telling you regarding the etiology, diagnosis, and symptoms is not original. Only a few points regarding the application of the technique are original with me.

The etiology of otitis media with effusion is the result of closure of the membranocartilaginous part of the Eustachian tube producing an inadequate ventilation of the middle ear cavity. The difference of pressure between the air of the middle ear and that of the surrounding atmosphere creates a partial vacuum in the middle ear, resulting in vascular engorgement and eventual transudation and exudation of serosanguinous fluid. During the act of swallowing, minute amounts of air enter the middle ear and often can be observed within the fluid of the tympanum. This effusion of fluid is not always confined strictly to the middle ear, but often fills the Eustachian tube and entire mastoid cavity. A few of the factors responsible for closure of the Eustachian tube are acute rhinosinusitis, acute exacerbations of chronic rhinosinusitis, nasal allergy, aero-otitis media, nasopharyngeal new growths in the region of the tubal orifice, and other causes, proving the etiology to be not singular.

A history of influenza, upper respiratory infection, or an airplane ride usually precedes the onset of the ear symptoms. Impairment of hearing, head noises, a heavy, full feeling in one or both ears, a change in the sound of the patient's voice to himself are some of the symptoms complained of. If the etiology is the result of difference of atmospheric pressure encountered in a rapid descent in an airplane there might be experienced severe pain and vertigo along with the other symptoms mentioned.

The diagnosis is not too difficult if a carefully taken history is followed by a thorough examination. The picture or appearance of the drum is not constant but is a passing panorama of pathological changes produced by the cause, and duration of the occlusion of the Eustachian tube. The drum is usually retracted, discolored, decreased light reflex, yellow-colored fluid in the middle ear, a serum line, and at times, air bubbles of varying size are noted. The latter alter their position on movement of the head. In many cases, the ear drum will be thickened making visualization of the middle ear contents through the drum impossible. An audiometric examination might show a true picture of obstructive deafness mild to severe, a mixed or nerve type alone. Auscultation while gently inflating the ear through an Eustachian catheter might permit the examiner to hear the sound of fluid in the middle ear. I feel positive that these pathological changes are not infrequent following many of the upper respiratory infections and following rapid descent in airplanes. However, I feel equally positive that many of these pathological changes and symptoms disappear after a reasonable period of time and leave no ill effects in their wake. In those cases in which

*Read before Section on Eye, Ear, Nose and Throat, Arkansas Medical Society, Fort Smith, April 18, 1950.

the symptoms are very annoying and show no tendency to subside in a reasonable period of time, the procedure to be described is safe, very gratifying to the patient, and, to a great extent, prevents any permanent impairment of hearing.

Bernard C. Trowbridge, M.D., Sc.D., in describing a new treatment of acute aero-otitis media recommends removal of the fluid in the middle ear by aspiration. Preceding introduction of the needle, he mentions topical application of a solution to produce anesthesia of the drum membrane.

Dr. J. Dudley Singleton, in his paper "Catarrhal Otitis Media With Effusion," does not use anesthesia nor aspiration. Our method of treatment of this pathological entity is similar in many respects to his. Following our examination when we feel that evacuation of the middle ear of suspected fluid is indicated our procedure is as follows. Time and equipment only prevent us from taking colored pictures of the tympanic membrane.

An audiometric examination is made. The ear canal is cleaned with alcohol. If the drum is markedly retracted (as it is in many cases) an Eustachian catheter is introduced and air is insufflated into the middle ear causing the drum to bulge away from the promitory. Next, without anesthesia, a small puncture is made into the drum and again the Eustachian catheter is introduced and air gently forced into the middle ear forcing secretions in varying amounts (often an unbelievable amount) into the canal of the ear. The audiometric examination is repeated. A small amount of sterile cotton is placed into the external auditory canal, the patient is given 1 cc. of Duracillin intramuscularly, and is instructed to return for observation the following day. It is seldom that this procedure must be repeated. However, in a few cases, it was done twice during the period of one winter, and in one case the procedure was repeated twice last year and once this year with excellent results. In the latter case, no specific etiology could ever be determined. In children, I have upon a number of occasions resorted to general anesthesia, that is when all conservative measures including displacement have failed to bring about resolution. Upon occasion this procedure was instituted at the time of removal of adenoids, adenoids and tonsils combined, or combined with making naso-antral windows. The treatment of children is, I believe, more important than the treatment of adults. I have many reasons for this belief; to mention a few: the lymphoid tissue is more predominant in children, the anatomy is more miniature in structure, the size and shape of the Eustachian tube is infantile, allergy is probably more a factor than in adults, therefore resolution must be slower and resulting permanent hearing defects more numerous.

Prognosis must depend on numerous factors such as the general physical condition of the patient, occupation, climate, the presence and degree of nasal allergy, the age of the patient, the duration and frequency of the pathological changes. The sooner the middle ear and environs are free of the accumulated fluid the shorter the convalescent period, and the less the danger of resulting aftermath.

Summary: Otitis media with effusion is not an uncommon disease, and too often is overlooked in children and adults, with resulting permanent impairment, to some extent, in hearing.

The procedure outlined is safe, simple, and usually sure.

The patient must not be promised too much, and must be told that the procedure might have to be repeated.

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RESOLUTION

WHEREAS, an all-wise providence has seen fit to remove from our midst, Dr. John S. Poe, who was our valued co-worker and a faithful member of the Pulaski County Medical Society, since May 1, 1950, we the members of the society mourn and deeply regret his sudden departure.

WHEREAS, as a physician in his chosen field of psychiatry he attained a great measure of distinction and won the respect of his colleagues, as well as the gratitude and love of a host of sorrowing people.

THEREFORE, BE IT RESOLVED, that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of the Society and its heartfelt sympathy to the family at the untimely loss that they have sustained.

BE IT FURTHER RESOLVED, that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy sent to the Journal of the Arkansas Medical Society.

THE USE OF PHYSOSTIGMINE IN THE TREATMENT OF THE BLACK WIDOW SPIDER BITE

O. R. HOLLOWAY, M.D.
Morrilton

The black widow spider (Latrodectus Mactans) is prevalent in Central and South America and to a lesser degree in North America. In North America it is found most commonly in the southern part of the United States. The black widow spiders are inhabitants of woodpiles, under boards, under privies, in dark corners, in closets and in other such dark places. Their common inhabitancy under seats of privies cause numerous bites on genitalia.

The black widow spider deposits in its bite a toxalbumin venom the fractions of which produce paralysis of the ascending motor nerves and destruction of peripheral nerve endings.[1] Immediate manifestations consist of redness and swelling at the site of the bite, accompanied by sharp pain. After the venom has been absorbed by the lymphatic system, weakness, dizziness, and trembling in the legs occur. Pronounced abdominal cramps, rigidity and spasm of the abdominal muscles resemble an attack of acute appendicitis. In the advanced stage there may be renal, cardiac, pulmonary, and nervous manifestations.

In recent years several reports of incidence of black widow spider bite have appeared in the literature. As of October 1948 four hundred cases with sixteen deaths had been reported in the United States.[2] Six cases occurring in a tropical area within a period of a week were reported by Greer.[3] These cases all presented similar symptoms; typical of those of the black widow spider bite. Relief was obtained with treatment consisting of a 10-cc. injection of a 10 per cent solution of calcium gluconate and a subsequent injection of saline solution containing 10 cc. of 10 per cent calcium gluconate. An ice pack was applied locally. Miller,[4] in Kentucky, reports that hardly a year goes by that he does not treat 3 to 5 black widow spider bites. He gives intravenous injection of 10 to 20 cc. of calcium gluconate solution rapidly, following this with intramuscular injection of horse serum and 1 to 2 units of Latrodectus Mactans antivenin after intolerance has been ruled out. If required, additional calcium gluconate is given after 5 or 6 hours.

*A stabilized solution of physostigmine salicylate and atropine sulfate, marketed under the name of Phyatromine(R), by Kremers-Urban Company, Milwaukee, Wisconsin.

Report of Cases

I would like to report two cases which came to my attention recently, and which I treated successfully with a combination of physostigmine and atropine.* Both cases presented symptoms which were definite manifestations of the black widow spider bite. Both were relieved 10 to 15 minutes after administration of the preparation of physostigmine and atropine (Phyatromine(R)). In one case 1/4 gr. of morphine sulfate was given simultaneously.

CASE 1. White male 28 years of age previously in good health, who gave a history of being bitten by a black widow spider about two hours before being treated by me. When first seen the patient was writhing in pain. He was on the floor, refusing to be put to bed. His abdominal musculature was drawn in rigid knots and his extremities were partially rigid. He had difficulty in breathing. His temperature was 102, pulse 122, respiration 28. Without further examination, he was given a deep intragluteal injection of 1.5 cc. Phyatromine(R) plus 1/4 gr. morphine sulfate. Ten minutes later he began to relax and in another five minutes he was completely relaxed and smoked a few puffs of a cigarette. Further treatment consisted of relieving him of his toxicity. He recovered completely without residuum.

CASE 2. A negro male 20 years of age previously in good health, who gave a history of having been bitten by an unknown insect which he "thought to be a black widow spider." The patient was seen by me two hours after the bite occurred, at which time he presented symptoms similar to those described in Case 1. He was given 2 cc. Phyatromine(R) only. In a little over 15 minutes the muscular spasm was relaxed. The usual procedure for counteracting the toxicity was followed. The patient was fully recovered without ill effects.

Discussion

This is a very simple and convenient way of treating the patient for relaxation of muscular spasm caused by the toxins of the black widow spider bite. According to Greer[3] some sixty medicaments have been employed in treating the patient for symptoms of the black widow spider bite. Included are calcium gluconate, antivenin, convalescent serum, neostigmine methylsulfate. The preparation which I have used successfully, Phyatromine(R), is a stabilized solution containing 0.6 mg. physostigmine salicylate and 0.6 mg. atropine sulfate per cc. The medication was effective in relaxing the muscle spasm in 10 and 15

minutes respectively, as well as relieving the pain and other accompanying symptoms. The pharmacological action responsible for relaxation of muscular spasm, rigidity, and pain believed to ensue as a result of the spasm, associated with arachnidism is not clearly understood. It is known, however, that physostigmine inhibits the action of cholinesterase in body and fluid tissues, thus permitting acetylcholine which is liberated at the nerve endings to exert its full effect. Atropine counteracts the muscarinic action of acetylcholine.

Summary and Conclusions

Two patients who presented themselves for treatment of symptoms resulting from the toxins of the black widow spider bite were successfully treated with a preparation of physostigmine and atropine. No untoward effects were experienced.

It is concluded that Phyatromine(R) may be safely used to combat muscular spasm from poisons of the black widow spider, and possibly might be used in cases of other insect or reptile poisoning.

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2. Queries and Minor Notes, J.A.M.A. 138:720 (Oct. 30) 1948.
3. Greer, W. E. R.: Arachnidism: Effect of Calcium Gluconate in 6 cases. New England J. Med. 240:5 (Jan. 6) 1949.
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UNIVERSITY OF ARKANSAS
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Office of The President

August 5, 1950.

Dr. W. R. Brooksher, Secretary
Arkansas Medical Society
Fort Smith, Arkansas
Dear Dr. Brooksher:

Enclosed is a statement of policy which I offer for publication in the State Medical Journal in the belief that its publication will clear up any existing misunderstandings. As I understand it, the policy is in accord with the ideas of members of a committee of the Arkansas Medical Society who contacted me regarding the matter.

The University is anxious to have the cooperation of the doctors of the state in carrying on our program for medical education.

Sincerely yours,

Lewis Webster Jones
President.

STATEMENT OF POLICY

1. The University of Arkansas welcomes and desires the cooperation and support of the Arkansas State Medical Society and its component parts. There should be frequent consultation and a free interchange of ideas between the two organizations seeking to serve the people of the State of Arkansas.

2. It is the aim of the administration of the University to emphasize in the School of Medicine the training of doctors for general practice. Special attention is also to be given to postgraduate education in this field.

3. It is the policy of the University of Arkansas School of Medicine to employ full-time staff members who shall devote their chief energies to research and teaching. This policy would preclude the competitive practice of medicine by the full-time faculty. The full-time staff should have every opportunity to perform certain services, including consultation work, largely in other hospitals such as the Veterans Hospital, State Hospital for Nervous Diseases and the Army and Navy Hospital.

4. The care of private patients in the Medical Center is not contemplated. The hospital is designed to care for teaching cases. The Medical Center will have the burden of caring for patients from over the entire state referred to it by local doctors, and the assistance of the doctors of the state will be helpful in referring significant teaching cases.

OBITUARY

NAPOLEON R. HOSEY, Marvell, age 74, died July 24th. A graduate of the Memphis Hospital Medical College, he had practiced in Arkansas since his graduation in 1909. He was an honorary member of the Arkansas Medical Society.

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NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

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EDITORIAL

CALLS TO MILITARY SERVICE

During August the armed forces called their first reservists to duty from Arkansas. On the first call from the Army, 27 physicians were ordered for final type physical examinations. In a meeting with the Commander, Arkansas Military District, the situation with reference to this and subsequent calls was discussed with the Council and members of the newly-formed Procurement and Assignment Committee of the state society. This committee has no official status such as it held during World War II, but the Society decided that its reactivation was wise at this time in order that it might be prepared to function should the national committee be again authorized. The Army has indicated that it will receive the recommendations of the committee in all good faith where deferment of a called reservist physician may be the decision of the committee. It is not possible, due to rapidly changing conditions, to publish here the policies of the armed forces on recruitment of physicians. As often as practicable the Society will advise the membership by special bulletin of important changes in policy of the Department of Defense.

To date, the armed forces have admirably restrained their efforts to recruit needed medical manpower to voluntary action on the part of physicians. This is in keeping with the record of medical men of recognizing their responsibility in time of war and of performing their duty to the fullest in any emergency. However, there are efforts being made for compulsory enrollment of physicians in the armed forces with especial emphasis upon those physicians who, as medical students, were deferred from active military duty to study medicine, and in many instances, whose medical education was paid for by the United States government.

There is every reason to believe that before such legislation is passed by Congress, and that is but a short time away, that these physicians will volunteer to serve their country.

POSTGRADUATE STUDY COURSES

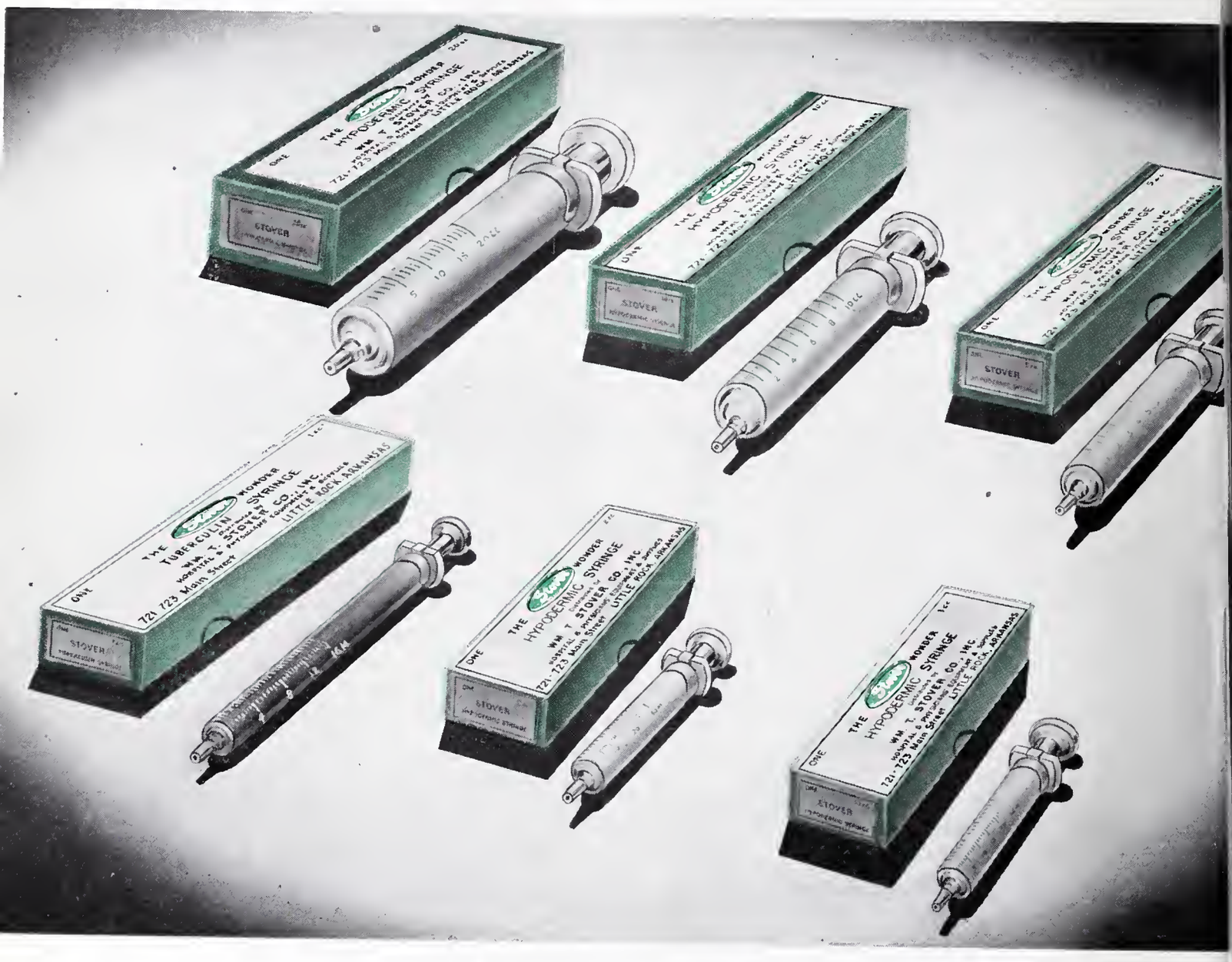
The Committee on Postgraduate Education of the Arkansas Medical Society and of the Arkansas Chapter, American Academy of General Practice have arranged for a series of postgraduate study courses to be conducted at the University of Arkansas School of Medicine during the school year. Tentative assignment of courses to be offered is presented here and physicians wishing further information may address the head of the department of the medical school. Additional news as available will appear in The Journal.

Date	Department	Head of Dept.	Number
Oct. (1st half)	Obstet. & Gynecology	Willis E. Brown	15
Oct. 27	Acad. of Gen. Pract.		No limit
Nov. 6-7	Pediatrics	W. A. Reilly	No limit
Nov. 13-16	Southern Med. Soc.		
Dec. (1st half)	Surgery	G. O. Dean	25
Dec. (2nd half)	None to be held		
Jan. (1st half)	Obstet. & Gynecology	Willis E. Brown	15
Jan. (2nd half)	Tuberculosis		No limit
Feb. (1st half)	Medicine	B. B. Wells	30
Feb. (2nd half)	Mid South		
Mar. (1st half)	Surgery	G. O. Dean	25
Mar. (2nd half)	Obstet. & Gynecology	Willis E. Brown	15
Apr. (1st half)	Radiology	I. Meschan	
Apr. 23-25	State Society Meeting		
May (1st half)	Pediatrics	W. A. Reilly	No limit
May (2nd half)	Obstet. & Gynecology	Willis E. Brown	15
June (1st half)	Surgery	G. O. Dean	25

THE SAN FRANCISCO SESSION OF THE AMERICAN MEDICAL ASSOCIATION

The 1950 session of the American Medical Association held in San Francisco was attended by 10,119 fellows and members. Among the important actions of the House of Delegates were the following: Establishment of dues for members

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1 cc. Tuberculin	1.50	17.40
2 cc.	1.20	13.80
5 cc.	1.50	17.40
5 cc. Ecc. Tip	1.90	22.20
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Capacity	Each	Per Doz
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20 cc.	2.20	25.8
20 cc. Ecc. Tip	2.65	30.8
30 cc.	3.00	35.4
30 cc. Ecc. Tip	3.25	37.8
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at $25 for 1951 to include subscription to The Journal of the American Medical Association; continuation of the National Educational Program under the direction of Whittaker and Baxter for another year; took action through the Hess report with a view to discouraging hospitals from practicing medicine for profit by hiring salaried physicians; provided for further study of the "Tennessee" plan for home-town medical care of veterans; declared that mass cancer surveys are the job of the family physician and should be directed by state and county medical societies; installed Elmer L. Henderson as President in a televised broadcast of a meeting of the House of Delegates; elected John W. Cline, San Francisco, President-Elect; Thomas P. Murdock, Connecticut, and Leonard W. Larson, North Dakota, Trustees, and R. B. Robins, Camden, Vice-President; to urge Blue Shield and private insurance carriers to include nursing services as a part of their health insurance programs; immediate action on civil defense mechanisms recommended with full medical society support in all states; recommended steps to emphasize general practice in undergraduate years and for the development of general practice residences; and presented its Distinguished Service Award to Evarts A. Graham, Saint Louis.

DEFEAT OF REORGANIZATION PLAN NO. 27

Once again the Legislative Branch of the Federal Government has conclusively shown that it recognizes the attempts of the Executive Department to give Cabinet status to its chief proponent of compulsory health insurance. Reorganization Plan No. 27 of the President received a decisive defeat in the House of Representatives, thus piling up the second defeat by the Congress, while, at almost the same time, Senator McClellan's Committee on Expenditures in the Executive Department was giving the plan a 6-3 unfavorable report.

These actions by members of Congress indicate that our legislators are well-informed on the issues of compulsory health insurance and the plans of the Executive Department to force it upon the American people.

At this time, it seems particularly important that we demonstrate that the medical profession is making every effort to provide medical care to the American people under voluntary plans. We should increase our activities in the expansion of our Blue Cross-Blue Shield plan in order that the major portion of Arkansas citizens may have its services available to them in illness.

RANDOM THOUGHTS OF THE SECRETARY

July 30th. The Council earnestly debates military preparedness and medical manpower this day reaching conclusions which seem proper and fair to all although there must needs be full cooperation if the needs of the armed forces and the civilian population are to be equitably met.

August 13th. The Council meets in discussion of medical manpower and of "Procurement and Assignment," words which mean "this is the place where we came in" to Dan Autry and to this former Procurement Chairman.

August 14th. Tonight the Sebastian County Medical Society pays homage to that excitable, enthusiastic little man who has given freely of time, energy and money for the good of medicine in his 38 years of membership—Davis W. Goldstein.

August 15th. Busily engaged in the examination of National Guardsmen who are shortly to enter active service and we recall predictions of ours that "rough going is ahead" and so it is.

August 20th. Today the Council and the Procurement and Assignment Committee meet with Colonel Cort seeking answers to the many questions which follow the call to duty of 27 Arkansas reserve officers, obtaining a few of the answers with intimations as to others. We do not profess to analyze sentiments but there is obvious agreement as to order of call to active military service in line with the resolution of the Society. Surely there will be volunteers from those who have been urged to see their duty at this time, releasing, for the moment at least, those medical officers who served in the last war.

THE DEMOCRATIC PARTY IS COMMITTED

JACK WILLIAMS
(Member of The Star's Washington Bureau)

Washington, June 23.—William M. Boyle, Jr., Democratic national committee chairman, ordered his party workers today to open up on the doctors and give compulsory health insurance a top billing for the fall campaign.

Viewed from the political standpoint, Boyle's move to put the health plan at the top of the issues is seen as good strategy. There are more patients than doctors.

The technique has been used in other fields by politicians. An outstanding example of vote-getting strategy has been the arraying of employees against a much smaller number of employers.

Seen as Boon to Patients

Boyle, in his weekly letter to party workers, blasted away at the American Medical Association and cited figures which he said showed patients would benefit by the politically-proposed health program.

"The American Medical Association," Boyle said, "has announced an advertising campaign of $1,100,000 to attack the President's national health program as 'socialized medicine,' which it

is not, and to argue that Blue Shield plans make national insurance unnecessary.

"Undoubtedly it will be designed to confuse the American voter about what the administration's national health program is and about the extent of the Blue Shield coverage."

Boyle then listed what he described as the "true facts" so that "the voter may be given them by Democratic workers."

Covers Only 10 Per Cent

"Fewer than 10 per cent of the persons in the United States are covered by a Blue Shield plan, which is an organization run by a medical society," he said.

Missouri was listed by Boyle as one of ten states where the Blue Shield voluntary plan covered 10 to 20 per cent of the people. Kansas was listed in the 5 to 10 per cent group. Seven states have no Blue Shield plan, Boyle said.

The party chieftain served notice that it was to be an all-out battle against the doctors down to the precincts.

"As to the charge of 'socialized medicine,' " Boyle wrote the Democratic workers, "next week the letter will discuss that charge in detail and give you the facts about the health program the A.M.A. is fighting with a million-dollar advertising campaign."

A plan similar to the one proposed by the administration is in operation under the British Socialist government.

Cost Is Higher, He Says

Boyle contended the average family cost of Blue Shield and Blue Cross voluntary health plans combined was $80 to $85 a year, against a cost of $48 under the administration compulsory health program.

"The Blue Shield plan proposes to provide 'voluntary medical care insurance' but actually covers only a part of your doctor bills, usually only surgery and often not all of that," Boyle told party workers.

He contended the Democratic party's plan gave coverage of all medical requirements, including doctor calls at the home, and medicines.

"At the end of 1949 the Blue Shield Medical Insurance plans, sponsored by medical societies, had an enrollment of 13½ million people," the party letter continued. "This is only 9 per cent of the population. The enrollment is mostly in a few industrialized and relatively wealthy states. Fifty-two per cent are in six states, California, Massachusetts, Michigan, New York, Ohio and Pennsylvania."

—K. C. Times, 6-24-50.

CORRESPONDENCE

AMERICAN CYANAMID COMPANY
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July, 1950.

Parathion Poisoning

Dear Doctor:

Parathion (O, O-diethyl O-p-nitrophenyl thiophosphate) has proved so highly efficient as an insecticide or pesticide that its importance economically is apparent and its usage is rapidly becoming widespread in agricultural communities. Unfortunately parathion is highly toxic for man as well as for insect life. It may be handled and applied safely if, and only if, stringent precautions are strictly observed. However, in spite of the emphasis placed on the need for such precautions excessive absorption may occur through relaxation of these precautions or through accidental heavy exposure. Physicians may therefore be confronted with cases of poisoning from this compound. The management of acute poisoning by a cholinesterase inhibitor is a medical emergency of a type seldom if ever up to this time encountered in medical practice. The following summary of information now available should therefore be of interest to physicians. From this it will be apparent that in this medical emergency the proper timing and dosage of the antidote atropine may be life saving.

The systemic effects of parathion are qualitatively similar to those of other cholinesterase inhibitors, and to the effects of the acetylcholine analogues (pilocarpine, muscarine, arecoline, mecholyl, doryl). Effects of parathion are interpreted as the result of accumulation of endogenous acetylcholine at synapses of the nervous system. They include giddiness, headache, nausea, vomiting, abdominal cramps, diarrhea, miosis, sweating, salivation, lachrymation, confusion, weakness, and muscular fasciculations. A sense of tightness is felt in the chest as the bronchi constrict and fill with mucus. Fatalities appear to result from constriction and secretions in the bronchi or arrest of the heart. On the other hand, recovery from the acute poisoning is usually complete and uneventful. There has been no evidence of permanent injury in such cases.

Treatment may be effective if atropine grains 1/100 to 1/50 (0.65 to 1.3 milligrams) is given at once and every hour or oftener as needed to keep the patient fully atropinized (mouth dry, pupils dilated). If the lungs have filled before the atropine takes effect, clear the bronchi by postural drainage. Oxygen is then indicated. Morphine is contraindicated. Muscular fatigue and weak-

ness may reach a degree requiring artificial respiration. Following even mild symptoms no additional exposure to parathion or other phosphate esters should be allowed until time for cholinesterase regeneration has been allowed.

Intoxication by parathion or other CE inhibitors is an acute episode of 24 to 48 hours. It is terminated by cholinesterase regeneration and is followed by period of gradually decreasing susceptibility to small exposures. Successive parathion exposures may deplete cholinesterase reserves progressively and create a susceptibility to small doses of tetraethyl pyrophosphate or vice versa. Since CE is regenerated rather slowly in man, patients who have suffered parathion poisoning should not be permitted to experience further possible exposures to this compound until it has been established that CE blood levels have returned to normal. Parathion and other phosphate insecticides are not locally irritating, but they produce local cholinergic effects. There has been no chronic or cumulative action other than that on CE as previously described. Dangerous parathion residues have not been detected on food crops sprayed at the proper stage before harvest.

Very truly yours,

American Cyanamid Company
D. O. Hamblin, M.D.
Medical Director.

PROCEEDINGS OF SOCIETIES

Announcement is made of the Regional Meeting of the American College of Physicians to be held at the Mayo Hotel, Tulsa, Oklahoma, September 30th. The following program will be presented: "Recent Advances in the Diagnosis and Treatment of Cerebral Vascular Disease," R. E. Carpenter, Oklahoma City; "Relationship of Vitamins to Disease," Paul Day, Little Rock; "Anterior Pituitary Insufficiency," Paul Strong, Tulsa; "Pulmonary Emphysema: A Diagnostic and Therapeutic Problem," John J. Donnell, Oklahoma City; "What's New in Medicine," Howard C. Coggeshall and Arthur A. Hellbaum, Oklahoma City; "Panel-Gastrointestinal Diseases," Wann Langston, Oklahoma City, Walter L. Palmer, Chicago, Jerome S. Levy, Little Rock, S. C. Shepard, Tulsa, and Harry A. Daniels, Oklahoma City; "Steroids Other Than Cortisone in the Treatment of Rheumatoid Arthritis," Ralph Patterson, Hot Springs National Park; "Diseases of the Esophagus," Bert E. Mulvey, Oklahoma City; "Pulmonary Silicosis," H. A. Brocksmith, Muskogee; "Role of Potassium in the Body," John B. Morey, Ada; "Modern Concepts of Hepatitis in Cirrhosis," Alfred Kahn, Little Rock, and "Clinico-Pathological Conference," Leo Lowbeer and Robert H. Bayley, Oklahoma City. Members of the Arkansas Medical Society are extended a cordial invitation to attend by A. A. Blair, Fort Smith, Governor for Arkansas. Members desiring to attend are requested to notify Dr. Emry G. Hyatt, Springer Clinic, Tulsa, Oklahoma.

Craighead-Poinsett County Medical Society met at Jonesboro August 2nd with the following scientific program: "Coronary Occlusion and Its Treatment," S. F. Strain, Memphis.

J. H. McCurry, Secretary.

PERSONALS AND NEWS ITEMS

H. H. Holt has been elected medical adviser of the Nashville post of the American Legion.

W. F. Barrier has been elected surgeon of the Malvern post of the American Legion.

Rex Williams has been elected surgeon of the Siloam Springs post of the American Legion.

Friedman Sisco has been elected surgeon of the Springdale post of the American Legion.

Earl Parsons, Jr., Little Rock, was recently notified by the Menninger Clinic, Topeka, Kansas, that he had been selected to participate in research work concerned with direct psychoanalysis of schizophrenia, under the direction of Milton Wexler of the Clinic staff.

R. L. Armstrong has been elected surgeon of the Stamps post of the American Legion.

D. E. White recently addressed the El Dorado Rotary Club on "Socialized Medicine."

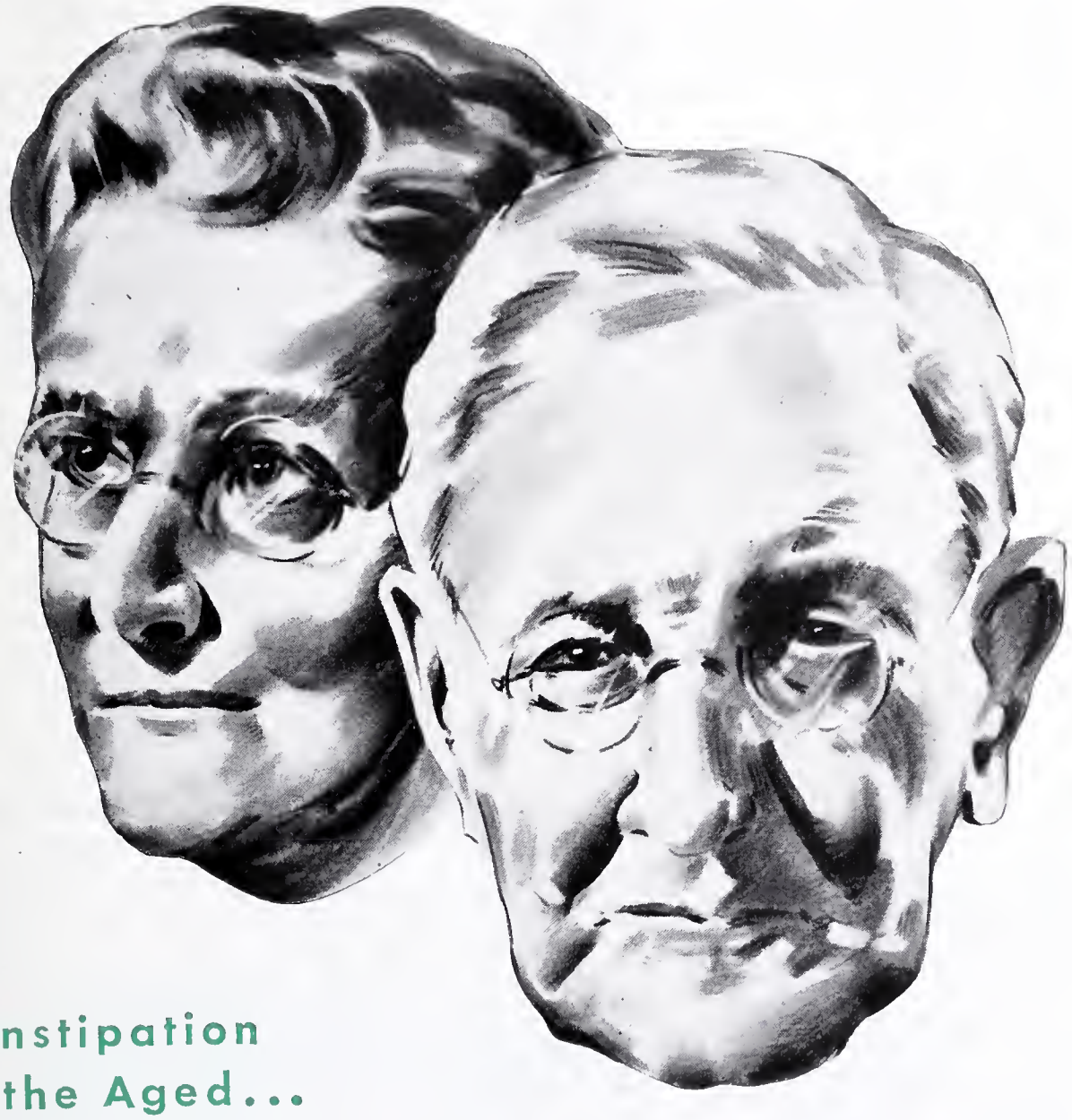
Jud B. Martindale is now associated with James G. Martindale in practice at Hope.

Joe A. Norton is now associated with Drs. Rhinehart in Little Rock.

Dr. and Mrs. Gordon Oates, Little Rock, spent a recent vacation in Texas.

Ralph E. Crigler, Fort Smith, has been appointed a Trustee of the State Sanatorium for Tuberculosis.

Drs. Reagan and Roberts announce the associa-



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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

tion with them in the practice of urology at Little Rock of Grady W. Reagan, Jr.

Dr. and Mrs. R. G. Kramer, Fort Smith, spent a recent vacation in Minnesota.

WOMAN'S AUXILIARY NEWS

Mrs. Fred Ferguson of Nashville, Ark., attended the Annual Convention of the Woman's Auxiliary to the American Medical Association June 26-30 in San Francisco, Calif.

The Auxiliary to the Pope-Yell County Medical Society met Thursday evening, August 10th, for a dinner meeting at the Eureka Cafe.

The meeting was called to order by Mrs. William O. Young, Vice-President. Five members were present. A report was given on distributing magazines to St. Mary's Hospital and sending a box of pocket-size books to Booneville Sanatorium. A committee was appointed to see about getting space for our booth at the County Fair in September, also to write for Blue Cross-Blue Shield literature to be distributed at the Fair.

Mrs. Max Mobley, Reporter.

The Auxiliary to the Craighead-Poinsett County Medical Society met at Hotel Noble for dinner with the Doctors on Wednesday, August 2.

After dinner the Auxiliary adjourned to the Gazelle Room for their meeting. The Vice-President, Mrs. Grover Poole, presided. Minutes of the last meeting were read and approved. A motion was made that the Constitution and By-laws sent out by the State Committee be accepted.

Each member present contributed 25 cents, for the purpose of buying hourglasses to give each doctor in the medical society to help carry out a publicity campaign against socialized medicine.

There were fourteen members and two guests present.

Mrs. Joe Ledbetter, Secretary.

The Auxiliary to the Southeast Arkansas Medical Society met July 17, 1950, in Lake Village. After a fish dinner with the doctors the ladies went to an adjoining room at the Country Club and spent a most enjoyable evening playing bingo.

There were sixteen present, including five guests who were: Mrs. W. A. Reeder, New Orleans, La.; Mrs. H. H. Towler, San Antonio, Texas; Mrs. C. W. Anderson, Mrs. James T. Rhyne, and Mrs. Howard Stern, all of Pine Bluff.

Mrs. Van C. Binns, Secretary.

Important messages are presented in the advertisements in our Journal each month. New products are announced from time to time and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be **used in your practice, in your office and in your home.** You can rely on the statements and facts presented. We aim to include only ethical advertisements in our Journal. Please tell the advertisers that you saw their ads in the **Journal of the Arkansas Medical Society.**

When you peruse the advertising pages in our Journal, remember this: all ads are carefully screened—the items, services and messages presented are committee-accepted. Our standards are of the highest. The advertisers like our Journal—that's why they selected it for use in their promotional program. They seek your patronage and your response encourages continued use of our publication. In turn, the advertisers' patronage helps us to produce a Journal that is second to none in our state. When you send inquiries, tell them that you read their advertisement in the **Journal of the Arkansas Medical Society.**

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OCT 17 1950

The Journal of the Arkansas Medical Society

Vol. XLVII FORT SMITH, ARKANSAS, OCTOBER, 1950 No. 5

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*Based on average reparted values for milk.

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Vol. XLVII FORT SMITH, ARKANSAS, OCTOBER, 1950 No. 5

CARDIAC FUNCTION AND THE EMOTIONAL STATES*

LOUIS FAUGERES BISHOP, JR., M. D.
New York, N. Y.

The relation of cardiac function to the emotional states has been experimentally proved. This has been evident in the private practice of medicine. Before considering various cardiac disorders affected by the emotions, it is important to define as clearly as possible the modern concept of the emotions.

A very good concept advanced in 1949 was that many pieces of the jigsaw puzzle of mental diseases are still missing, and in some instances the design only surmised. The conclusion is almost inescapable that all mental disorder, like other disease, is the result of a disturbance in the normal physiology with resultant pathological processes, the whole doubtless influenced, as is the case in other fields of medicine, by disturbing environmental factors.

The foundation for this conclusion was laid by the studies of a number of earlier investigators, for example, Walter Cannon's report in 1915 on "Bodily Changes in Pain, Hunger, Fear, and Rage," closely followed in 1920 by Henry Head's "Studies in Neurology." Many investigators have further elucidated this theme, particularly the role of the thalamus and the hypothalamus, in conjunction with the cortex, in explaining the basically organic nature of the emotions. To be more specific, emotions (2) result from the action and reaction of the cerebral cortex and the diencephalon. The cerebral cortex is the immediate site of emotional consciousness.

Experimental work (2) has been done on certain emotional equivalents following lesions of the brain. Investigators have produced profoundly placid cats by removal of the neocortex; and they could later turn them into ferocious animals by adding a lesion in the archicortex. By producing lesions in the archicortex and mesocortex, various workers have produced fearlessness, exaggerated affectionate behavior, marked oral reactions, and excessive sex expression in monkeys. Sham rage has not been observed in monkeys or in man as a result of lesions. Possibly the difference in reaction between carnivora and primates is a species difference. The carnivora have need of a rage reaction in their hunting for food, whereas for a monkey rage at the time of his gregarious meal would be disorganizing.

What are the emotions? To answer this question, it must first be conceded that the physiology of emotion, and the effect of the environment, are really the crux of the matter. Only on the basis of such knowledge can psychiatry obtain a well-rounded comprehension of the fundamental pathology of mental emotions which may lead to reliable methods of prevention and treatment.

In general, the eight common emotions that cause physical illness are: Need for love, approval and recognition; anxiety, fear and worry; inferiority feelings; ambivalence, a mixed emotion of love and hate; guilt; ambition, or competition; and envy. While the need for love is a paramount emotional requirement, anxiety apparently holds first place in disturbing cardiac function.

Many investigators (3) have shown that emotional disturbances may have a profound effect on the circulation, particularly on cardiac function, evidenced by changes in the heart rate, cardiac output, blood pressure, tone of peripheral vessels, and the electrocardiogram. This is particularly true of the emotional state which may develop in persons who find themselves in a hazardous situation.

Most workers agree that in the majority of persons anxiety has an effect on the circulation similar to that produced by a small dose of epinephrine: the cardiac output, the heart rate, and oxygen consumption are increased. There is a moderate elevation of blood pressure, but the peripheral resistance has decreased. The cardiac output is abnormally high in proportion to the rate of oxygen consumption. In certain subjects anxiety may be attended by circulatory collapse. In such cases in which peripheral resistance is decreased, the compensatory increase in cardiac output fails to occur, with a resultant fall in blood pressure to low levels.

*Read before 74th Annual Session, The Arkansas Medical Society, Fort Smith, April 17, 1950.

In recent experimental studies (4, 5), it has been observed that as part of the reaction to stressful life situations, as associated with tension, frustration, conflict, anxiety, and depression, the cardiovascular apparatus may react with several types of responses: these may be of two kinds, a hyperdynamic and a hypodynamic response. In a hyperdynamic circulatory reaction there is an increase in the cardiac output; in addition there may be a rise in blood pressure. In the hypodynamic reaction (less commonly observed than the hyperdynamic), an actual drop occurs in the cardiac output and blood pressure to levels below that of the initial, or resting, state; this response has been elicited even in healthy subjects who have felt "let down" or betrayed.

Not only sinus tachycardia, but cardiac arrhythmias of all types, with or without evidence of organic cardiovascular disease, may be caused by the emotions, including tachycardias arising from an ectopic focus. The relation between paroxysmal auricular fibrillation, and flutter, and the emotional states has also been noted. In a recent report (6) the emotional state of the patient was found relevant to the occurrence of the arrhythmias, in that extrasystoles could be produced experimentally during the discussion of topics to which the subjects were known to be sensitive, or which had been associated previously with extrasystoles. It appeared that excitability of the heart might be significantly altered by prolonged hyperactivity of the cardiac muscle during anxiety, with resultant tachycardia and increased stroke volume.

The effect of emotion on angina of effort (7), presumably due to insufficiency of the circulation of the coronary arteries, is often seen. Pain is such a common complaint (8), so far as the cardiologist is concerned, that it is perhaps unnecessary to emphasize the effect of the emotions on cardiac pain. After the doctor has made his difficult and often almost impossible decision, whether the pain falls into the functional category with its various synonyms or whether it is a true angina of effort with its basic lesion, coronary disease, the emotional problem is always present.

Due to the fact that in angina pectoris there are often no positive physical findings, and in addition a teleoroentgenogram and electrocardiogram may be within normal limits, in the last analysis the diagnosis must be based on the history alone. There is evidence that reduction of oxygen supply to the heart muscle may be caused by narrowing or occlusion of the coronary arteries, or reduction of the caliber of the arteries through vasomotor reflexes. There is strong evidence that vasomotor reflexes may play an important part in the production of attacks at any given time; and it is well known that these reflexes may be initiated by strong emotional stimuli (9).

It has long been observed that an intense emotional situation can produce an immediate attack of angina. More recent studies point to the fact that man reacts not only to actual danger but to the threat and symbols of assault in his past which call forth reactions little different to those experienced at the time of the actual assault. In the care of a patient suffering from angina a study of the life situation and of the emotional factors assumes deep importance.

The effect of the emotions on hypertension is recognized by all clinicians. A careful study (10) in 1945 indicates that the existence of a high blood pressure is usually first observed within a year after the inception of an emotional disturbance; and in this series, within three to eight years, the emotional upheaval apparently continuing to exert its influence in these patients throughout a long period.

It is well known that the date of onset of arterial hypertension is not easily established, and yet the synchronous occurrence of significant emotional disorders with the onset of hypertension in the series quoted (10) is very striking. A careful study of the emotional experiences in such cases would seem to point to a sudden loss of dependent security with which was associated, or applied, an actual threat of death. This was not, nor in any sense need be, a new occurrence, but in these particular patients similar patterns had occurred in their past. One almost common emotional factor was loss of security and exposure to the aggression of the person upon whom the person now depended.

Arterial hypertension differs clinically from many of the diseases which have been investigated from the emotional standpoint by reason of its insidious onset. It may exist unknown to the person for sometime before becoming manifest, or has been demonstrated by the sphygmomanometer. Hypertension is a general disease, involving an organ system of which the sufferer has no awareness. No patient ever at first complains of "high blood pressure." He may complain of the fact that he has been told that he "is suffering from high blood pressure," and he fears its consequences. More likely is it that he complains of symptoms such as headache, nervousness, irritability, or impairment of his sense of security.

The marked variations in blood pressure readings due to emotional reaction are too well known

to all clinicians to deserve comment. In the examination of men for pilot training, for example, during the last war, so characteristic was the rise in blood pressure above army regulations that it was deemed preferable to characterize such men with the letters, "E.A.R.," meaning "excessive aggressive reaction." If many of these men had been turned down on account of such a rise in blood pressure during examination, many fine pilots would have been lost to the air force. Whether this type of blood pressure later develops into a true hypertensive state, no one can apparently say.

Undoubtedly, emotional stress is recognized as an important etiological factor in neurocirculatory asthenia. It is not uncommon to find the induction of symptoms following prolonged combat training, or through suggestion from doctors, or by warnings from relatives. The impression that the so-called "effort syndrome" is a manifestation of the anxiety state has been strengthened during the last world war, although some cardiologists are not entirely satisfied that it is a purely psychosomatic manifestation. The term, "the emotional state," has been rather loosely employed. The term, "anxiety," has many connotations. And it is recognized that other reactions occur, such as resentment or anger, depending upon the individual and the circumstances.

This condition in at least one experience (11) was an example of a specific response in one man, twice repeated, to the conditions of war. The fluidity of this condition was well illustrated by this soldier examined during the last war. He presented a rather classical picture of neurocirculatory asthenia. When forced to separate him from the service, an interesting point came to light, that he had been separated from service in World War I for the same condition. From his history it had been learned that he had made a fair adjustment to his life as a farmer, but when faced with conditions, successively, in both wars, his symptoms became markedly aggravated. This condition may be difficult to detect in the routine examination of candidates for induction into the army. Not until faced with the physical and emotional strain of war does such a person with neurocirculatory asthenia become incapacitated.

Another similar case (12) was reported from England during the last war: "A corporal aged 49 had had palpitation, dyspnoea, and precordial pain while serving with the German army in the first great war. The symptoms subsided at the end of the war. After experience of a concentration camp he developed an anxiety state, but he had no further symptoms referred to the heart until he entered the British army during the present war. The symptoms of which he had complained in the first war then recurred, though his service employment was limited to the light work of a storeman, and he was considerably freer from physical and mental stress than he had been in Germany."

It is generally agreed that effort syndrome was noted less in the last world war than in 1914-1918.

Recent studies (13) indicate that in a number of patients who had suffered from anxiety, and followed over a long period of time, few rarely developed organic heart disease. This was reported despite the current belief that cardiovascular disease has been considered to be caused by anxiety, and particularly, hypertensive disease. It has also been noted that although neurocirculatory asthenia is usually a chronic disorder, it does not interfere significantly with the person's work, social, or family life, nor does it cause death. As illustrated by the two cases quoted above (11, 12), often it has become manifest, or increased, when such a person is faced with hazardous undertakings, such as combat training for war.

In treatment, the emotional aspects of cardiovascular disease are incompletely studied unless adequate physical and laboratory tests are done. The organic component must be as carefully evaluated as possible, no matter how minimal it may appear. Reassurance of the patient is often impossible without the operation of such technic. If disease is present, it may be important to explain that the symptoms are out of proportion to what is found wrong, and that the explanation of these symptoms may well be on the basis of emotionally disturbing events. Frequently, winning the confidence of the patient by showing interest in his problems and suffering, and by making him feel worth while, are all that is necessary. The advice of more work and useful endeavor, instead of rest, may be indicated, and result in dramatic improvement.

Before any help can be given the history must be carefully taken. Perhaps it might be stated that the careful history is the most important step in understanding the effect of the emotions on cardiac function. Many doctors have had to learn a proper interviewing technic (14) which was not taught in their medical school days. Learning to take adequate histories in patients with functional heart disease will pay very large dividends. The confidence established in the physician by the patient, by reason of demonstrable interest in his case, together with a complete cardiac examination, and a simple explanation of the disturbance, is psychotherapy in its simplest form. A large number of persons respond to such treatment. There are certain cases in which the

emotional factor is so preponderant that they cannot be helped by such management, requiring careful analytical study, and should be referred to a specialist.

The use of drugs (14) should not be neglected in patients in whom the cardiovascular functional aspects predominate.

On account of the profound effect of the emotional state on cardiac function, a consideration of the life situation of the patient should play an important part in the management of a patient suffering either from functional or organic heart disease.

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A SERIOUS COMPLICATION OF THROMBOPHLEBITIS IN SAPHENOUS VARICOSITIES*

FRANK G. KUMPURIS, M.D. and ALFRED KAHN, M.D.
Little Rock

Introduction

A little emphasized complication of thrombophlebitis in the incompetent saphenous vein is the propagation of a free lying thrombus beyond the area of acute inflammation. The literature has been filled in recent years with the differential points of superficial thrombophlebitis and deep venous thrombosis (5, 6). One consistant feeling is that the superficial type of process is accompanied by an inflammatory process which makes it less susceptible to the breaking off of emboli, whereas, the deep thrombosis, accompanied by a much less amount of inflammation, is far less safe and more prone to causing embolic complications and the propagation of a free thrombus (2). However, there are isolated references in the literature of propagating thrombus occurring in the superficial varicosities; this problem deserves more consideration (3, 8, 9).

Rosenblatt (7) reports a case of free lying thrombus one and a half inches long in the femerol vein which had silently propagated from an original thrombophlebitis in a varicosed saphenous vein in the calf; this, being found during ligation at the sapheno-femoral junction, was unsuspected. In the above incident no serious complication occurred, but Barrow (1) reported a somewhat similar case which terminated fatally; Barrow's case was of a 49-year-old white female who died of a pulmonary infarction secondary to thrombophlebitis in a varicosed saphenous vein (proven at postmortem). One of three cases of pulmonary infarction reported by Sears was fatal (8).

Another complication of thrombophlebitis of the superficial system is the propagation of a thrombus through the communicating veins to the deep venous system (2). The diagnosis of the deep venous thrombosis is difficult to make because of the overlying superficial thrombophlebitis.

Case Report

Our attention was directed to this problem because of the following case:

Mr. G. K., aged 54 years, had a history of varicosed saphenous veins for 20 years. While on a recent vacation, he had a sudden severe

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pain in the area of the left knee on the medial aspect. This pain was constant, burning, not relieved by rest, and exaggerated by walking. In addition, he noticed that the varicosities in this area were swollen, tender, and the entire area was hot. Three days after the onset, he consulted one of us. Physical examination revealed all of the above mentioned signs and symptoms to be present, with the process apparently localized in a 10-centimeter area in the region of the medial aspect of the left knee. Oral temperature at the time was 101 degrees Fahrenheit. For 24 hours the patient was treated conservatively with bed rest and heat to the extremity. At this time, a firm, non-tender, cylindrical mass measuring approximately 10 by 1 centimeters was felt extending ceohalad along the course of the saphenous vein from the area of acute inflammation. The superior tip of the mass did not seem to be any closer than 12 centimeters from the fossa ovalis. This was interpreted as a cephalad propagation of a bland thrombus, and surgery was advised.

Surgery was performed within two hours after the cord-like structure was felt. Under anesthesia, the sapheno-femoral junction was exposed, and a free lying thrombus was found in the saphenous vein. The tip of this thrombus extended to within one centimeter of the sapheno-femoral junction; the thrombus was at least 11 centimeters closer to the femoral vein than had been suspected after careful physical examination. The clot and a section of the saphenous vein with all of its tributaries were removed. The patient made a rapid and uneventful recovery.

Discussion

It is of interest to note that this patient had a full blown thrombophlebitis in which the propagating thrombus was definitely non-tender. Moreover, of equal interest was the extent of the thrombus beyond the physical signs. Considering the type of thrombus found at surgery, it was indeed fortunate that this patient did not have an embolic phenomenum. The patient's recovery was very rapid, which coincides with Homan's (5) statement that surgical ligation promotes a more rapid recovery of the thrombophlebitis than the more conservative medical therapy.

Conclusions

1. This case report represents the cephalad propagation of a silent bland thrombus secondary to thrombophlebitis in a varicosed saphenous vein. The importance of this complication of thrombophlebitis in a varicosed vein is emphasized.

2. The bland thrombus may extend well above the physical signs.

3. The thrombus may propagate through a communicating vein and involve the deep venous system of the lower extremity.

4. Thrombophlebitis in a varicosed vein may be the site of origin of embolic phenomena.

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CORRESPONDENCE

August 17, 1950.

W. R. Brooksher, M.D.
Ft. Smith, Arkansas.

Dear Bill:

I noticed in your Editorial in the "Arkansas Medical Journal" in regard to Dr. R. B. Robins of Camden, Ark. being the first Arkansas doctor to be honored nationally by the A.M.A. If you will look up the records you will find the following in Dr. Vinsonhaler's "History of the Arkansas Medical Society" on page 11. It says Dr. P. O. Hooper of Little Rock, Arkansas, was elected Vice-president in 1882; and Dr. J. J. Woodard was elected President. The A.M.A. met at St. Paul, Minn. in 1882 on June 6th. Owing to the illness of Dr. Woodard, Dr. P. O. Hooper presided at that session.

So you see, Dr. Hooper was the first doctor to be honored nationally. Now, Bill, you are always right most of the time but you did not read your history enough.

With best wishes and kindest personal regards, I am,

Yours sincerely,

L. T. Evans, M.D.

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EDITORIAL

CLEVELAND SESSION OF THE AMERICAN MEDICAL ASSOCIATION

The fourth annual clinical session, with emphasis upon general practice, will be held by the American Medical Association in Cleveland, December 5th-8th, 1950. The clinical sessions have proved most popular with the physicians of America. Over 4,000 attended the 1949 session in Washington, D. C. Newer treatments and diagnostic procedures will be discussed in the full range of medicine. Color telecasts, an outstanding feature of recent sessions of the American Medical Association, will be presented from the University Hospital. Arkansas physicians are advised to make early application for hotel reservations.

RANDOM THOUGHTS OF THE SECRETARY

September 6th. Suggested nominations to the Republican party: Eisenhower and a Marine.

September 8th. We will wager that on the White House walls there is no hanging motto: "Tell It to the Marines."

September 15th. Tonight we sit in a steady downpour to watch the first football game of the season pondering "Does youth remain or has judgment departed?" that we would sit through this for a mere football game.

September 13th. Long feared for its coming, today arrives and Bill takes off for college.

September 21st. Conversations with Butler and Butts and discussions with the P & A chairman, Richardson, at Fayetteville this afternoon, another of many pleasant visits to Washington county.

THE BRITISH HEALTH SERVICE

The special American Medical Association committee on study of the British health system reported to the House of Delegates at the San Francisco session and its report has been printed in the August 19th issue of The Journal of the American Medical Association. Careful reading of this report will be of interest to all American physicians.

The committee reaches the following conclusions: 1. The total cost of the service has exceeded all estimates and it does not appear that the cost peak has been reached. 2. Although a large amount of money has been expended for health of the British people, there is no evidence that there has been any significant improvement in either their health or their happiness. There are long waiting lists for hospital admissions. Offices of general practitioners are overcrowded. Essential services have suffered from the expenditure of funds for non-essential services.

3. The standing of the general practitioner has suffered in grievous degree.

4. Nothing in the way of preventive medicine has been gained but, on the contrary, public health activities have been disrupted.

5. Medicine finds itself under almost autocratic control.

6. Present abuses of the system will inevitably lead to more restrictions and regulations.



ANSWERS TO QUESTIONS ABOUT DRAFTING DOCTORS

The following information was prepared in the Washington Office of the American Medical Association in an attempt to answer questions which might grow out of the doctor-draft.

Who Must Register?

Physicians and dentists who have not reached the age of 50 and are not members of military reserves definitely will be required to register; the law was written to reach this group. The President also may require the registration of veterinarians, optometrists, pharmacists, osteopaths and/or those in other specialist categories. But the law specifically excludes military reserves; they already are subject to military orders.

Who Are Eligible for Draft and in What Order Will They Be Called?

Any registrant (above) is subject to induction if acceptable to the military. The law provides that registrants will be called up on the following priority:

1. Former ASTP and V-12 men who have not served on active duty (military, Coast Guard or Public Health Service) and others deferred from service to continue their education during World War II, and who have had less than 90 days of active duty.

2. Members in the above groups who have had more than 90 days active duty but less than 21 months.

3. With no reference to above groups, those who did not have active service (military, Coast Guard or Public Health Service) subsequent to September 16, 1940; this could include postwar medical graduates as well as other physicians who have not served and have not reached their 51st birthday.

4. All others, including World War II non-reserve veterans. Men in this group are to be called on the basis of extent of duty, those with the least duty first.

When Will the Draft Take Effect?

Not until the President sets a time for registration. The registration deadline may be announced before this is printed. Men will register at "appropriate points of registration" in the community. After registration, Selective Service will place the man in one of the four classes listed above. Then, if he is to be called, he will be ordered up for his physical examination. After this he has 21 days to set his affairs in order before reporting to the Armed Forces Induction Station. Subsequently, he will be offered a commission and assignment to a service.

Can a Registrant Get a Reserve Commission?

Yes, if acceptable to the military. If the man applies for and is granted a reserve commission, he will come under military orders and Selective Service will not process him further.

Who Gets the $100 Pay Bonus?

Every reserve officer called to duty, on a voluntary or involuntary basis, receives the extra $100 per month. Men required to register under this act also may qualify for the $100—but only if they volunteer prior to their actual induction.

Who Is Eligible for Deferment?

Actual deferment is at the discretion of local Selective Service boards. However, the law states that "the President is authorized to provide for" certain deferments. Action under this clause would be based on the registrant's previous military service, his dependency status and any undue hardship that might ensue.

Will the Medical Profession Advise Selective Service on Men to Be Called?

Yes. The law provides for establishment of a National Advisory Committee "which shall advise Selective Service system and coordinate work of state and local volunteer advisory committees with respect to selection of needed" professional personnel. The Committee will be composed of men "outstanding in medical, dental and allied services." The medical and dental professions must be represented on the National Committee, but representation of other professions is not required. The law does not control local advisory committees; whether these are established and made effective depends on local conditions.

Will the Draft Create Critical Doctor-Shortage Areas?

Conceivably it might. But the law itself attempts to set up safeguards. It says that the national, state and local committees shall "give appropriate consideration to" civilian as well as military medical and dental requirements. Another section underscores this policy: "Maintenance of national health, safety or interest" should be considered in granting deferments. In calling up reserves, Army commanders also are under orders to give careful consideration to doctor-shortage areas.

How Many Will Be Drafted?

Military medical officers hope that enough men now will volunteer to meet requirements. They are prepared to use the law's authority for mandatory inductions but are confident that these cases will be rare. They are hopeful that the $100 bonus, which is denied to men involuntarily in-

ducted under this act, will induce most registrants to volunteer.

Other Provisions

One section of the law authorizes transfer of medical officers from one service to another, with consent of the officer and of the services involved. The officer is protected in promotion, retirement and pay. . . . Another provides that any person who has served in the armed forces or Public Health Service after September 16, 1940, and is recalled, may be "promoted to a grade commensurate with his education, experience and ability." . . . The law states "it is the sense of Congress" that Selective Service deferments will be granted to premedical, pre-dental and allied students in numbers equal to the present such enrolment. This ruling more or less formalizes the present Selective Service policy and sets a total figure for deferments in each professional category. . . . Inductees under the doctor-draft law are required to serve 21 months. . . . Anticipation is that Advisory Committees will operate like the Procurement and Assignment Boards of World War II. . . . The bonus of $100 now goes to all reserves, whether called up voluntary or involuntarily; on this Congress reversed the comptroller general, who had ruled that reserves called up involuntarily were not eligible. . . . The doctor-draft law, an amendment to the Selective Service Act, expires with that law next July, unless extended by Congress.

—Jo. A.M.A., Sept. 16, 1950.

OBITUARY

WILLIAM S. KENDALL, age 63, of Cave City, died August 26th of a heart attack. Born in Smithville, Arkansas, October 24, 1887, he graduated from the Kansas City College of Medicine and Surgery in 1918. In that year he began practice at Jesup, Arkansas, moving to Strawberry in 1921. He located at Cave City in 1941. He was a past-president of the Lawrence County Medical Society, a member of the Masonic bodies, the Shrine and of the Methodist church. Surviving relatives are his wife, two sons and a daughter.

VICTOR P. DIEDRICH, age 64, of Hot Springs National Park, died July 18th. A practitioner in orthopedics at Hot Springs National Park for over 30 years, he suffered a heart attack in September, 1949, and had been in temporary retirement since that time. Born in Madison, Wisconsin, he graduated from University of Illinois College of Medicine in 1911 and in addition to his membership in the Garland County Medical Society and the Arkansas Medical Society, he was a Fellow of the American Medical Association. Surviving relatives are his wife, two brothers and two sisters.

WILLIAM ALVIN BUTT, age 67 years, died at his home in Green Forest July 31st after an illness of several months. Born in Illinois, March 31, 1883, he graduated from the College of Physicians and Surgeons, Little Rock, in 1910 and had practiced at Green Forest since that time. Surviving relatives are a son and four daughters.

PERSONALS AND NEWS ITEMS

The Arkansas Diet Manual, prepared by the Arkansas State Board of Health and the Arkansas Dietetic Association and endorsed by the Arkansas Medical Society, is now available. Copies are being distributed to each physician in the state. This manual stresses the use of foods commonly consumed in Arkansas. Eighty-five of the most widely used diets are included. In addition, copies of many of these diets, prepared for use by the patient, may be ordered without charge from the Arkansas State Board of Health. Order blanks are in the back of each manual.

Stanley Applegate recently addressed the Business and Professional Women's Club of Springdale on Korea.

Members of the Society who may wish to present papers at the 1951 annual session are requested to communicate with the Chairman of the Committee on Scientific Work, Dr. J. W. Kennedy, Arkadelphia.

W. L. Davis is now associated with M. C. Hawkins, Jr., at Searcy.

Carl A. Rosenbaum, Little Rock, has been reappointed a member of the Arkansas State Cancer Commission.

Charles R. Henry, Little Rock, addressed the annual convention of the Arkansas State Nurses' Association at Hot Springs National Park, Sep-

tember 15th, on the subject, "Organization and Functioning Within the Community for Total Patient Care."

Jeff Baggett and W. L. Newton have been elected surgeons of the American Legion posts at Prairie Grove and Smackover, respectively.

H. H. Buckelew has been elected chief of staff of the Rogers Memorial Hospital.

The American College of Surgeons has approved the tumor clinics conducted in Arkansas: University Hospital, Little Rock; Southeast Arkansas, Pine Bluff; Sebastian County, Fort Smith; South Arkansas, El Dorado; St. Vincent's Infirmary, Little Rock; Bowie-Miller Counties, Texarkana, and Northeast Arkansas, Jonesboro.

R. B. Robins, Camden, addressed the Washington State Medical Society at Spokane, September 12, on socialistic trends in government.

A physician is wanted for admissions officer, who is under 65 years of age but unable to engage in active practice. This is institutional work and inquiries should be sent to the editor.

Dr. and Mrs. Henry Hollenberg, Little Rock, spent an August vacation in Michigan.

L. H. McDaniel, Tyronza, recently addressed the Booneville (Mississippi) Rotary Club on "Old Age." "The Doctor's Heart," by Dr. McDaniel, originally published in the Southern Medical Journal, was published as a full-page advertisement by the druggists of Shreveport.

R. B. Robins, Camden, addressed the Texarkana Lions Club recently on "American Medicine's Story."

A postgraduate pediatric course will be given at the University of Arkansas School of Medicine on November 6 and 7, 1950. This course is sponsored by the Pediatric Department, University of Arkansas School of Medicine, Maternal and Child Health Division of the State Board of Health and the Arkansas Medical Society. Two prominent practical speakers from other parts of the country will be here to add to the success of the course. All interested physicians, nurses and public health workers are invited to attend. No fee will be charged for this course.

PROCEEDINGS OF SOCIETIES

Ouachita County Medical Society met at Camden September 7 with the following scientific program: "Surgery in the Aged," Peter O. Thomas, Little Rock.

Craighead-Poinsett County Medical Society met at Jonesboro September 6 with the following scientific program: "Northeast Arkansas Crippled Children's Program," John T. Gray, Jonesboro.

A symposium on "Low Back Pain" was presented at the September 11 meeting of the Pulaski County Medical Society.

E. F. Gray, Secretary.

The Tenth Councilor District Medical Society met in dinner session at Fort Smith September 12th with Gilbert O. Dean addressing the meeting on recent advances in surgery. The 50-Year pin of the Arkansas Medical Society was presented to C. E. Benefield, Fort Smith. Officers elected are: President, C. W. Hall, Greenwood; Vice-president, Ben H. Pride, Fort Smith, and Secretary-treasurer, W. F. Scarborough, Clarksville.

The Southeast Arkansas Medical Society met in dinner session at McGehee August 21 with 37 members in attendance. L. K. Hundley, Pine Bluff, discussed the proposals of the state medical society for the call of physicians into military service. Paul H. Powers, Waco, Texas, spoke on "Skin Diseases."

The Annual Fall Assembly of the Arkansas Academy of General Practice will be held October 27 at the Albert Pike Hotel, Little Rock, from 8 A. M. to 5 P. M. with a full program in prospect. Randolph Ellis, chairman of the postgraduate committee, is in charge, with M. D. McClain handling local arrangements. All members of the Arkansas Medical Society are invited.

Fount Richardson, Secretary.

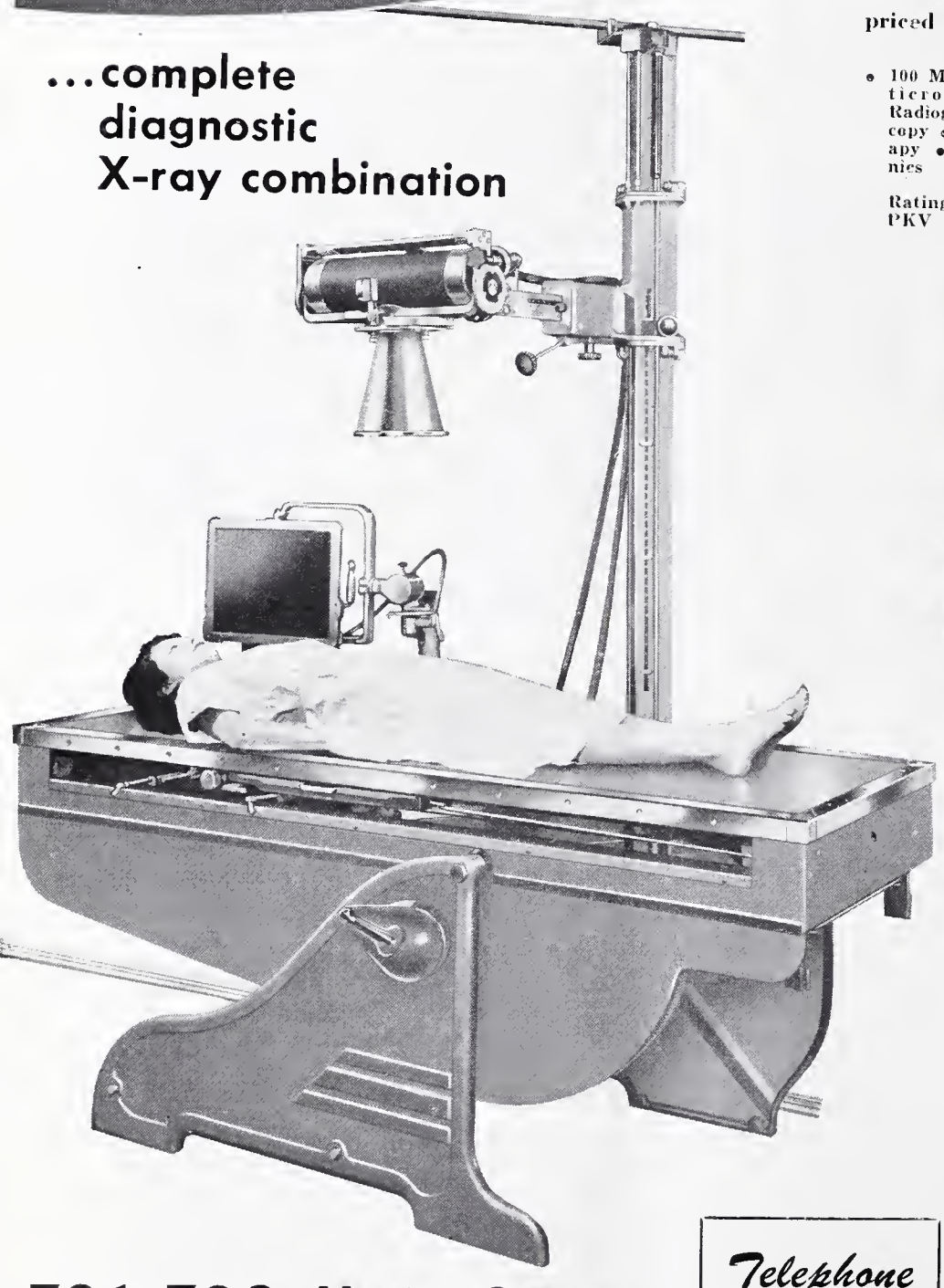
Distinguished guest speakers who will address the 28th Annual Fall Clinical Conference of the Kansas City Southwest Clinical Society, October 2-5, are, Jos. S. Barr, orthopedics; Brian B. Blades, surgery; W. E. Boland, medicine; W. L. Bradford, pediatrics; E. N. Broyles, otolaryngology; P. R. Cannon, pathology; Bayard Carter, obstetrics and gynecology; Elmer Hess, urology; Charles L. Martin, radiology; Alton Ochsner, surgery; Herman E. Pearse, surgery; F. E. Senear, dermatology; Dwight L. Wilbur, medicine, and Irving S. Wright, medicine.

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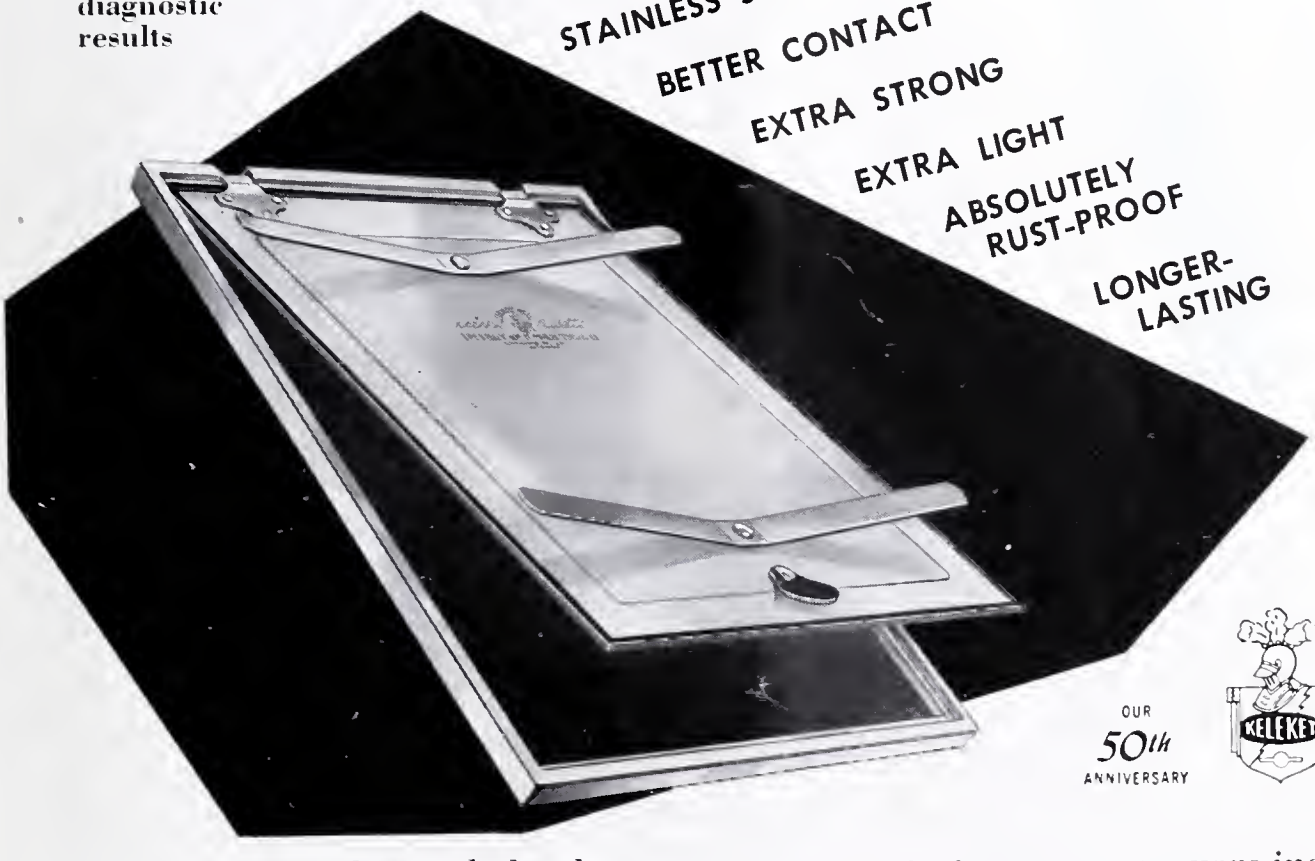
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WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary of the Union County Medical Society met in the home of Mrs. George Burton on September 8. The meeting was called to order by the President, Mrs. Paul Henley of Smackover. Mrs. Warren Riley, State President, gave a report on a meeting of radio managers of the state.

Plans were discussed for having an exhibit at the county fair, which opens here in El Dorado, September 25.

Mrs. Gardner Landers, Vice-president, and Program Chairman, gave a report for the coming year. The Auxiliary will have luncheon meetings on the first Wednesday of each month. Hostesses were named as well as program topics for each meeting. Integrated into each meeting will be a brief informative discussion on current medical legislation which will be conducted by Mrs. Leston Fitch.

There being no further business the meeting adjourned.

Mrs. J. O. Cooper,
Corresponding Secretary.

The Ouachita County Medical Auxiliary had their first meeting of the year last month. New and old business was transacted and some changes made in the election of officers. Plans were made for a booth at the County Fair to be held in September. We commended our Dr. R. B. Robins for being elected Vice-president of the A.M.A.

Mrs. James Guthrie, Secretary.

The Auxiliary to the Southeast Arkansas Medical Society met in McGehee August 21, 1950, at the Greystone Hotel. After dinner with the doctors, auxiliary members went to the home of Mrs. Swan D. Moss. The meeting was called to order by the President, Mrs. Lewis Hyatt of Monticello. The minutes were read and approved. The treasurer's report was read. The student loan fund was discussed. Mrs. H. T. Smith made the motion that the same amount be sent this year as last to the student loan fund, Mrs. Charles W. Dixon seconded it and the motion carried.

The following people were called upon to make statements: Mrs. Charles W. Dixon, biographies; Mrs. James T. Rhyne, Council Woman for the district; and Mrs. L. K. Hundley, past president.

Under Old and New Business the President discussed and distributed literature that she had received on Health Insurance.

There were 22 present, including six guests, who were: Mrs. L. K. Hundley, Mrs. Fred Hames, Mrs. C. W. Anderson, Mrs. Howard Stern and Mrs. James T. Rhyne, all of Pine Bluff, and Miss Nancy Anderson of Crossett.

The business meeting adjourned and an enjoyable social hour followed playing "Bugs" and Canasta.

Mrs. Van C. Binns,
Publicity Chairman.

The Woman's Auxiliary to the Craighead-Poinsett County Medical Society met with the doctors on September 6 for dinner at Hotel Noble. After dinner members of the Auxiliary met for a business session at the home of Mrs. Paul Stroud, President. There were 11 members present and two visitors.

Mrs. E. J. Stroud, Membership Chairman, was given a list of the members of the Craighead-Poinsett County Medical Society and asked to contact any eligible doctor's wife or widow regarding membership.

New legislature regarding the doctors draft was announced by the President.

Members were advised of the 13 weeks' radio programs which were being run over KBTM on Saturday morning at 9:00 A. M. This program is entitled, "Your Health Is Your Business." The first of these series was sponsored by the Reese Drug Store.

Mrs. O. T. Cohen was appointed Cancer Control Chairman and Mrs. Malcom Peeler appointed Doctors Day Chairman. It was requested that we finish the biography of our pioneer doctors this year and Mrs. L. H. McDaniel was appointed to work on this project in Poinsett County and Mrs. P. W. Lutterloh in Craighead County. The statistical report was discussed and explained. Plans were discussed for a booth at the county fair.

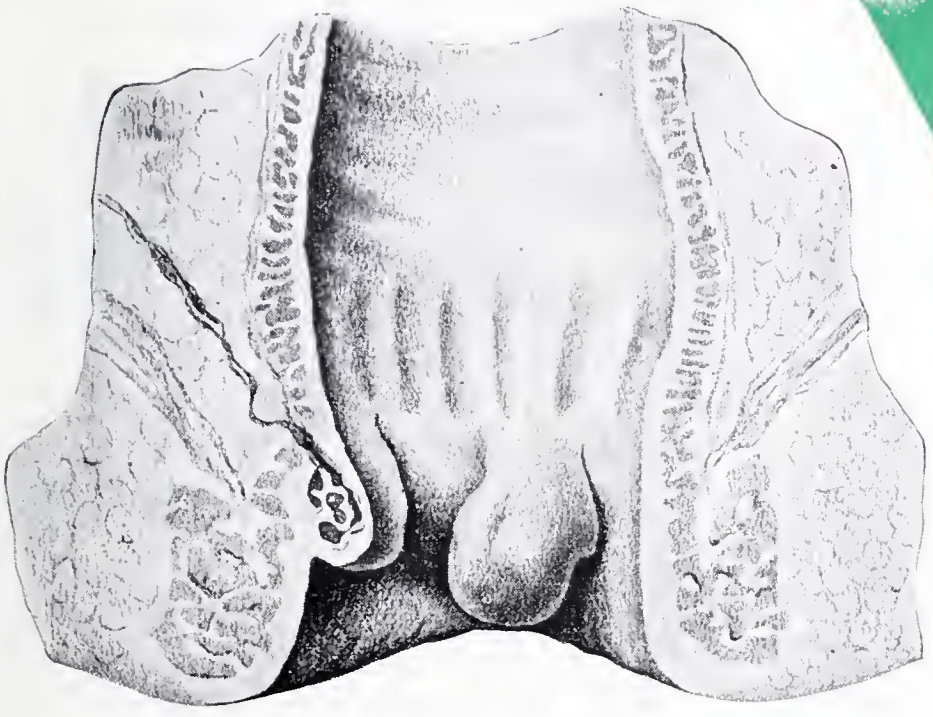
There being no further business the meeting adjourned.

Mrs. Paul Stroud, President.

Our first meeting of the year for Greene-Clay County Auxiliary will be a dinner meeting with the doctors on September 13. Dr. and Mrs. W. E. Berry of Jonesboro will be our guests. Dr. Berry will explain the new doctor draft rules. The Auxiliary will have a separate meeting and discuss the program plans for the year. We sponsored a booth at the County Fair which was held September 6-9. E.M.C. literature was distributed.

Mrs. A. D. Garner, President.

Mrs. M. L. Dalton, of Brinkley, was hostess to the Monroe County Medical Auxiliary at her home on June 7th. President, Mrs. E. D. McKnight, presided over the business session and reported on the state convention which met in



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Fort Smith in April. She outlined the program of the new state president, and led a discussion about the constitution of the state Auxiliary. The president appointed Mrs. Dalton to contact the Forrest City radio station in regard to a program on medical subjects of current interest to the public. It was decided that the program for the next meeting would be the forming of a local constitution, and the group was invited to meet at the home of Mrs. L. H. Stout, Brinkley, on August 2nd at 2:15 p. m. Other members present were Mrs. Herd E. Stone, Holly Grove, and Mrs. Ben Pupsta, Clarendon.

Mrs. E. A. McCracken, Reporter.

Mrs. Mason G. Lawson, Little Rock, Ark., was elected Second Vice-President of the Woman's Auxiliary to the American Medical Association at the June meeting in San Francisco, Calif., and Mrs. Louis K. Hundley, Pine Bluff, Ark., was elected to the 1950-51 Nominating Committee.

BOOK REVIEW

Plastic and Reconstructive Surgery—A Manual of Management: By Ferris Smith, M.D., F.A.C.S., Consultant in Plastic Surgery, Blodgett Memorial Hospital, Grand Rapids, Michigan. 895 pages with 592 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $15.00.

This book reveals the wide experience of the author in a type of presentation which is unique in text books. The basic concept of the responsibility of a surgeon doing plastic or reconstructive surgery is evidenced in every chapter. The subject material presented is very comprehensive but is given in such a manner that the reader can well detect many procedures of choice which may not at the moment be the popular thought in professional circles. The illustrations with these procedures are clearly defined and convey much with the author's description of the text presented. The section particularly dealing with fractures of the maxilla and mandible are well illustrated and review many of the principles and practices which our war-time plastic and reconstructive surgeons saw even in front line surgery. That section alone would be a decided aid to any individual who may be called upon to serve in the armed forces in the capacity of reconstructive surgeon should the present condition go on to World War III. The section on burns is excellent but probably could have been enlarged upon from the author's own experience. The author's reminder of the problem of sectional excision for various types of skin problems is well brought forth to give the reader the proper perspective on multiple stage procedures over a long period of time to produce excellent finished operative results superior to some of the shorter but more popular methods. The case histories are excellent in their presentation and in their illustrative value which is the desire of the author in preparing a volume slightly above the beginner in maximum value but definitely a volume of choice to those who would approach the subject with an open mind. The accumulation of basic principle, procedure of choice, and end result is an excellent foundation in study for those who would read from the pages of experience of their fellow practitioners.



PHYSICIANS of the South have an urgent call to St. Louis for the annual meeting of the **Southern Medical Association,** Monday, Tuesday, Wednesday and Thursday, November 13-16. Medical meetings are essential in times of war as well as in times of peace. In the light of the world situation today this meeting of the Southern Medical Association may be the last complete general medical meeting to be held for some time to come. With this thought in mind, it is very important that all physicians take advantage of this opportunity to bring themselves up to date on the latest developments in the profession.

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MEMBERS of state and county medical societies may attend. Eligible physicians, members of state and county medical societies in the South can be and should be members of the Southern Medical Association. The annual dues of $8.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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The Journal of the Arkansas Medical Society

Vol. XLVII FORT SMITH, ARKANSAS, NOVEMBER, 1950 No. 6

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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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AMEBIASIS: ITS DIAGNOSIS AND TREATMENT*

F. M. ACREE, M.D.
Greenville, Miss.

Of 23,000 admissions to the King's Daughters' Hospital in Greenville, Mississippi, over a period of 13 years ending January 1, 1950, a diagnosis of amebiasis was made in 385 cases, amebic colitis in 46 and amebic dysentery in 15, or a total of 446. These 446 cases represent an incidence of less than 2 per cent of the 23,000 admissions. Since many individuals who harbor E. histolytica have symptoms so vague as to remain unnoticed, this incidence is probably low. According to Bockus,[3] from 5 to 10 per cent of our population are infested with the organism. Of special significance, however, is the fact that of the total of 446 cases of amebiasis, the disease had reached the dysenteric stage in only 15, or 3.3 per cent. Further, a review of the hospital cases of dysentery of other types during the same 13-year period revealed bacillary dysentery in 25 cases and acute dysentery of unknown origin in 87, a total of 122. Thus, the number of amebic infections was more than three times that of all the dysentery cases combined.

From the above findings and similar observations by others, it is obvious that, in order to succeed in an appreciable measure in the control of amebiasis, we must abandon the concept that dysentery is a necessary feature of the disease. Rather, many patients present only mild or moderate gastrointestinal symptoms, none of them peculiar to amebiasis. In addition, they are prone to suffer from one or more of a multiplicity of complaints which, unless one is constantly aware of a possible relationship, convey no suggestion of an amebic origin. Boyers (4) analyzed the complaints of 700 patients with amebiasis and found a total of 1,961, including not only those referable to the gastrointestinal tract, but to the neuromuscular, respiratory, genitourinary, cardiovascular and glandular systems, the skin and mucocutaneous areas, eyes and ears, as well as a number of miscellaneous affections. One might add that amebiasis also manifests itself in symptoms referable to the bones and joints, the gallbladder, the liver, spleen and brain, the pericardium and, in fact, practically every structure in the body. Although such symptoms generally accompany those of a gastrointestinal disturbance, they may appear as the sole evidence of amebic infection.

For practical study, amebiasis might well be divided into four types or stages, following somewhat the classification described by Craig.[5] Patients with Type I infections are those who have no appreciable symptoms. They are the cyst carriers and those with mild infections, whose resistance is adequate to prevent serious inroads upon the intestine by the parasite. In such patients, the infection may persist for years without causing sufficient disability to be especially noticeable. The fact remains, however, that pathologic changes take place in the intestinal mucosa and, if antiamebic therapy is given, the patient becomes aware of a definite improvement in his general condition. In our climate, a large proportion of infected individuals fall into this class; thus, unless every patient is submitted to a most rigid questioning as to his symptoms, many who harbor the parasite will not be recognized.

Type II, which consists of those with mild symptoms, may be misleading from the diagnostic standpoint, in that the manifestations may be widely diverse in nature. Usually, however, they are traceable to the gastrointestinal tract and to the nervous or circulatory system. Constipation is commonly reported. Diarrhea, if associated at all, is not severe. Gaseous distention, abdominal pain which varies in intensity and location, nausea, an erratic appetite, weight loss, generalized aches and pains, tachycardia, nervousness and irratibility, frontal headache, mental depression, chronic fatigue and malaise are among the complaints reported. A sallow skin, low blood pressure and low grade fever may have a part in the syndrome. As an example of the symptomatic vagaries of this type, we

* Read before the Seventy-Fourth Annual Session, Arkansas Medical Society, Fort Smith, April 18, 1950.

recently observed a patient who presented no symptom other than a frontal headache. She had been treated repeatedly by a specialist on the assumption that the headache was of sinus origin. Our examination revealed an E. histolytica infection. Following antiamebic therapy, her headache disappeared. Such experiences impress upon us the necessity for stool tests as a part of routine examinations.

In the usual more advanced, or Type III, amebiasis, the syndrome centers upon the intestinal tract. Diarrhea of gradual or sudden onset, more or less severe, recurring at intervals and lasting for days or weeks, is the dominant complaint. In addition, symptoms referable to the nervous system or any other system or organ may appear, often to a pronounced degree.

Unless properly treated, a Type III syndrome may be followed by Type IV, or true amebic dysentery. Or, the dysentery may be sudden in onset, without previous evidence of the disease. In either event, the diarrhea is acute, the stools often numbering 10 or more daily and containing mucus, blood and fat, and tenesmus is more or less severe. Considerable abdominal pain of a cramping or colicky nature is a prominent feature at this stage, as well as chills and fever, emaciation and anemia. Symptoms referable to other regions are generally reported, and complications, such as liver abscess, may be associated.

Untreated cases of acute dysentery may persist, manifesting themselves in chronically recurrent, acute attacks, sometimes with fatal termination. Or, they may progress to a fulminating infection; here also, the outcome may be fatal, perhaps incident to perforation of the bowel wall and peritonitis. Again, a fulminant infection may develop without having been preceded by other attacks. It is probable, however, that in the majority of cases of sudden onset and rapidly fatal course, a bacillary or other type of infection is associated.

Diagnosis.—In view of the fact that the diagnosis of amebiasis is practically impossible from the symptoms and clinical findings, one must rely upon the demonstration of the E. histolytica in the feces, preferably by examination of three warm specimens following a purgative. Should no organisms be found, and provided the symptoms warrant, the test should be repeated. Several tests may be required before the E. histolytica are recovered, especially if the patient has few gastrointestinal symptoms. If one is still in doubt, cultures or concentration tests may show positive evidence of the amebae. If these methods fail, sigmoidoscopy may reveal the presence of the lesions in the sigmoid or rectum. Roentgenograms are also useful, particularly in the later stages. Infections in the cecum may present a contraction or shortening of this segment, or, a generalized infection may be exhibited by feathery or horny filling defects throughout the colon. Defects indicating fibrous or granulomatous changes are observed only in long-standing infections.

The differential diagnosis should include, not only the various types of dysentery, but the different forms of colitis and tuberculosis, appendicitis and carcinoma. The ulcerative form of colitis may usually be distinguished if specimens removed directly from the lesions through the proctoscope fail to reveal E. histolytica. Mucous colitis will be suggested by the presence of large quantities of mucus in the feces, with little or no evidence of blood. In this, as in other forms of colitis, however, the determining factor is the presence or absence of amebae.

Appendicitis probably presents the most frequently encountered problem in the differential diagnosis, especially since amebae are often found in the appendix. Microscopic evidence of amebiasis in patients with symptoms of appendicitis, therefore, suggests a therapeutic test while the patient is kept under observation; if the symptoms do not subside, operation may then be undertaken.

One may also easily mistake an amebic granuloma for a tuberculoma or a carcinoma. For this reason, roentgenographic evidence of a colon tumor calls for stool tests. Should these be positive, every effort should be made to determine the nature of the tumor before the patient is submitted to surgery. It should be remembered, however, that amebiasis may be associated with carcinoma, tuberculoma, or any other disease of the colon.

Treatment.—The drugs generally employed in the treatment of amebiasis are the iodine compounds, arsenicals and emetine. The iodine compounds have proved helpful in every stage of the disease, and particularly in the milder stages. Chiniofon and Diodoquin seem to be the favorites of these drugs. As a rule, one course of treatment cannot be depended upon to bring about a permanent recovery; in most cases, repeated courses are necessary. When properly administered, iodine is practically without toxic

effect, even in repeated courses. Some patients may have a mild diarrhea following its use, though this promptly subsides upon withdrawal of the drug.

Carbarsone is probably the most popular of the arsenicals in the treatment of amebiasis. For the past several months, we have been trying Millibis, a newer arsenic preparation, though, thus far, we have no reason to believe it is superior to Carbarsone. These drugs may be employed successfully, not only in the treatment of the cystic form of amebiasis and mild infections, but also in the most resistant types. In refractory cases, the course may be repeated. Occasionally, diarrhea and abdominal distention and, rarely, signs of injury to the optic nerve may follow their administration. We have, however, observed no serious reactions from its use.

The application of emetine is preferably limited to acute dysentery and amebic hepatitis. It has little or no effect upon the cystic forms of the disease. In view of its high degree of toxicity, especially its damaging effect upon the heart, patients should be kept in the hospital during its administration, that any toxic symptoms may be promptly detected. When such symptoms appear, the drug should be discontinued. Emetine should be avoided in the treatment of amebiasis in children, in pregnant women and in patients with heart or kidney disorders. Its repeated use, moreover, is inadvisable, in that emetine resistant strains of E. histolytica may develop. Since relapses within a few months after relief are common following the administration of emetine alone, a supplementary course of iodine or arsenic is advisable.

Within the past few years a great deal of research has been carried out with a number of other drugs in the treatment of amebiasis. For example, Anderson et al.[1] report on the use of two thioarsenites in 77 patients infested with E. histolytica. These drugs were found generally effective against both the motile and cystic forms of the organism, and gave no evidence of toxicity. Laird, et al.[6] described the results in 37 cases followed one to six months after treatment with aureomycin. They found this drug rapidly effective in the relief of symptoms as well as curative of both mild and severe forms of amebiasis. No serious toxic reactions were observed. These and others of the newer drugs are still largely in the experimental stage, however, and should be used with caution.

In addition to drug therapy, the patient with amebiasis should be kept on a diet free from rough and fatty foods, and those containing large quantities of sugar. In the acute forms, the diet should be restricted to simple broths and egg yolks. As the symptoms subside, a full diet may be gradually resumed. In any stage of the disease, alcoholic drinks and condiments should be forbidden and smoking permitted only in moderation.

An estimation of the results of any form of treatment of amebiasis may depend upon one or more of several considerations. In the first place, post-therapy studies should be complete. The number of cysts and motile organisms is greatly diminished following treatment; for this reason, a most careful search of a number of specimens, as well as repeated sigmoidoscopy may be necessary before one can be reasonably certain of a cure. Second, as Archer[2] and others have pointed out, the symptoms may persist even after thorough and prolonged treatment and repeated negative stool examinations. Apparently, such symptoms are induced by secondary infections which have developed in the diseased colon. In these cases, therefore, a search for other organisms is indicated. Third, one may find it impossible to determine whether a recurrence of symptoms and positive tests after a period of apparent cure are due to a relapse of the original disease or to a reinfection. Finally, even following an apparent cure and repeated negative studies, additional tests should be made from time to time in order that any organisms, whether remaining from an old infection or newly introduced, may be found before the damage reaches serious proportions.

Summary

1. At the King's Daughters' Hospital in Greenville, Miss., a diagnosis of amebiasis has been made in 446 cases over a period of 13 years; this represents an incidence of 2 per cent of 23,000 admissions. Of the 446 cases, dysentery was associated in only 15, or 3.3 per cent. From this, it is apparent that dysentery is a feature of relatively few cases of amebic infection.

2. A large number of individuals are cyst carriers or else have only a mild infection, thus experiencing few, if any symptoms of amebiasis. Those with a more active form of the disease may complain not only of a gastrointestinal disturbance of more or less severity, but also of symptoms referable to almost every structure in the body.

3. Amebic dysentery may follow a milder

infection, or may be sudden in onset. Unless treated, this type may become chronic. A fulminating infection may likewise climax acute dysentery or may develop without previous warning. Either type may be fatal.

4. The diagnosis is based upon the demonstration of the Endamoeba histolytica in the stool specimens. Repeated tests may be necessary. Should these fail to demonstrate the organism, sigmoidoscopy and roentgenographic studies may be employed. The differentiation from other forms of colitis, as well as from appendicitis, tuberculosis and carcinoma deserve special attention.

5. The treatment generally employed consists of medication with iodine compounds, arsenicals and emetine. The indications for each of these drugs are discussed. Diet is likewise an important feature of the treatment.

6. Several points to be considered in an estimation of the results are presented. Especially, a most careful search of a number of stool specimens, as well as repeated sigmoidoscopy, may be necessary before a cure may be regarded as established.

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DOCTOR, YOUR X-RAY TECHNICIAN SHOULD BE REMINDED . . .

The Arkansas Society of X-Ray Technicians will hold its second annual state meeting at the Majestic Hotel, Hot Springs National Park, November 18th-19th, 1950.

The meeting will consist of business and scientific sessions with several Arkansas radiologists participating in the scientific program.

A group examination for registration will be given on Friday evening, November 17th, conducted by S. Archibald Morton, M. D., of Milwaukee, Wisconsin, Vice-President of the Registry Board.

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K. W. COSGROVE, M.D.
Little Rock

Corneal grafting has been tried for years. Heterogeneous grafts have never been successful, neither has total keratoplasty. The method of grafting wherein a portion of the entire thickness of the cornea is removed and replaced by transparent corneal tissue is most applicable. Reisinger first tried this method in 1824 and was followed by others including Von Hippel, with little success. The first successful clear graft is credited to Zirm (1906). Since that time, the present technique has been developed through the work of Elschnic (Praque), Thomas (Eng.), Castroviego (NYC).

The glaring publicity attending this operation has blinded both the layman and the physician to the true facts. The general public has been so misinformed about the operation that people have been led to believe that "new" eyes can replace diseased ones.

In the first place, the indication for this type of surgery is very limited, according to Stansbury,[1] in a study of 122 operations.

Favorable conditions:

1. Small corneal scars that can be encompassed by a graft.

2. Large superficial corneal scars in corneas in which the graft will be surrounded by normal corneal tissue posteriorly.

3. Little or no corneal vascularization.

4. Absence of other ocular pathologic disease.

5. Keratoconus.

Unfavorable conditions:

1. Total, or nearly total, corneal opacification.

2. Extensive corneal vascularization.

3. Presence of other ocular pathologic condition, associated with the corneal lesion.

4. Degenerative processes of the cornea, such as: Fuchs's epithelial dystrophy, band keratitis, calcareous degeneration and primary fatty degeneration (possibly these degenerations should fall in the contraindicated group).

Contraindications:

1. Glaucoma.

2. Adherent leukoma.

The Eye Bank and obtaining eyes:

The eye bank is merely a cooling box which keeps the eye at an even temperature of 4° Centigrade. The eyes may be removed any time up to three hours after death (before embalming). The entire eye is removed and placed in sterile saline and cooled to 4° Centigrade. Eyes may be used which have normal cornea at any age. The premature eye is much more curved than the adult and only permits small grafts. The sooner the operation is done the more chance of the graft remaining clear. Clear grafts have been obtained from eyes kept up to five days.

The operation is not a difficult one except for the placing of the stitch. There are two types of grafts, the round graft cut with a trephine, and the square which is marked with a double-bladed knife and cut out with a keratome and special scissors. The size of the graft varies from 4 mm. to 7 mm. in diameter. Both grafts are cut on a bevel so that the new piece of cornea drops into the opening like a plug in a watermelon. The problem is to keep it there. Early grafts were held by a conjunctival flap. This was not too satisfactory because you could not see the graft for seven to ten days. Other conjunctival sutures give too much laxity because of the elasticity of the conjunctiva. The best suture is described by Castroviejo,[2] which is a web from each corner and center crossing over the graft from the cornea on each side. It is necessary to keep the patient quiet for about two weeks to permit solid healing.

The results are not at all as glamorous as have been pictured. Even in the most carefully selected cases only 50% can expect improvement in vision. In 100 selected cases done by Paton,[3] 55% were clear and 45% were cloudy. In Stansbury's report of 165 cases of all kinds, 22 improved vision, 86 remained unchanged and 57 had loss of vision.

Summary: Corneal transplantation is not the panacea for all blindness. It has its place in restoring visual acuity in certain selected cases.

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INCREASED CAPILLARY FRAGILITY FOLLOWING USE OF CORTONE ACETATE IN TREATMENT OF ARTHRITIS

ROY E. SCHIRMER, M.D.
Fort Smith

Mr. T J. F., white male, age 60, who has had arthritis for 25 years was started on injections of Cortone Acetate (Merck). He had had a total of 17 injections (1675 mgm.). He gave the following history: about 10 days prior to his first visit to the office, his wife called his attention to scattered red patches in skin of right leg below the knee (following the 15th injection). Following the 16th injection they noticed more on right and left legs. A pet cat scratched him on leg and large area of ecchymosis appeared around scratch. He was in the office two days after the 17th injection. Large patches of petechia, size of fifty-cent piece to silver dollar, were observed on left leg and buttocks, a large one almost covering the left popliteal space. There were numerous single generalized petechia. Some of the earliest were undergoing color changes. Patient denied taking any other medication. He complained of dull headache, and a burning sensation of lower extremeties, especially of soles of feet. These symptoms were not present before he noticed the "red spots."

Capillary fragility test—positive; Blood chemistry: bleeding time—normal; Coagulation time—normal; Prothromin—normal; Clot retraction—complete within 18 hours; Red Cell Fragility—normal; Platelet count 176,640; one week later, 236,500.

It is possible that there is a hypersensitivity to one of the substances used in the Cortone vehicle. All of the substances used in vehicle have been studied for toxic effects and have been found to be innocuous even at very high doses. It is still possible that a rare individual will show an allergic reaction to anyone of these substances.

It is hard to know if such an occurrence is a coincidence or represents cause and effect. It may be an isolated unusual type of sensitivity. The patient has entirely recovered since the treatment was discontinued.

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EDITORIAL

A.M.A. CLINICAL SESSION

The Fourth Clinical Session of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5-8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel. These sessions of the body elected to govern the affairs of the A.M.A. are attracting more and more non-delegate physicians each year.

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnosis, treatment and preventive measures as they fit into daily practice will receive the greatest attention.

Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

In obstetrics, difficult cases of interest will be featured. Especially stressed will be the general subjects of breach deliveries, induction of labor, indications for cesarean section, obstetric analgesia and anesthesia, and hemorrhages.

Clinical discussions featuring actual pediatrics patients have been programmed. The care of premature infants, acute diarrhea in children, rheumatic fever, preventive medical measures and psychiatric care for small children are among the interesting topics scheduled.

Because of the unusual interest displayed last year in the section devoted to management of heart cases, there will be a similar session this year. It will include discussions on hypertension, recent advances in drug therapy, including ACTH as it applies to heart disease, acute arterial occlusion and cardiac arrhythmias.

Of special interest will be discussions on Parkinsonism, the use of the electro-encephalograph, electric shock therapy and psychotherapy.

With more cases of fluid balance appearing because of the larger number of geriatric patients, there will be discussions on fluid replacement in shock, renal repairment, dehydration and other topics.

Of unusual interest will be the new studies and clinical histories involving traumatic surgery. This will include material on reconstructive surgery, emergency analgesia and emergency surgical measures.

Taken up in detail will be the management of post operative or inoperable cancer patients. The use of analgesics and the effects of harmone and radiological treatment will be discussed.

An excellent program has been arranged covering diabetes. This will include diagnosis, vascular complications, special consideration in pregnancy and surgery, and dietary problems.

Very timely will be the panel discussions and demonstrations on the diagnosis of poliomyelitis, the treatment of respiratory failure and the management of paralytic cases. There will be demonstrations of physical therapy and rehabilitation measures for poliomyelitis cases.

Papers covering practical problems in dermatology and syphilology will be presented. Deep fungous infections and industrial, allergic and contact dermatoses will be demonstrated and discussed. Emphasis will be put on the newest developments in syphiolology.

New developments and refinements of older

techniques will feature the discussions on anesthesiology. Spinal anesthesia, management of the surgical case, intravenous administration and other practical problems will be reviewed.

Outstanding speakers will discuss ulcers, jaundice, infectious hepatitis, cirrhosis and other gastro-intestinal diseases. Newest advances in medicine and the use of many newer drugs and their application to the general practice of medicine will be presented in another section. Of special interest will be the discussions on the use of antibiotics, hormones and antispasmodics.

Outstanding features of the scientific exhibits will be special demonstrations on fractures, diabetes, rheumatism and arthritis. Exhibits will be presented on cancer, pediatrics, chest diseases, surgical procedures and other subjects correlated with the clinical presentations.

Once again color television will take its place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium. It will be sponsored by Smith, Kline & French Laboratories.

The annual General Practitioner Award has come to be regarded as one of medicine's highest honors and a definite step toward increasing the recognition of the family doctor. This year's selection will be made at the Cleveland meeting.

The steadily climbing registration of general practitioners at the clinical sessions and the comments of those participating indicate these meetings are valuable means of keeping abreast of developments in medicine. It is hoped that a record number of physicians will take advantage of the opportunity in December to attend. The program has been designed with that in mind.

THE DOCTOR AND THE DRAFT

Considerable confusion apparently exists with a view to registration under the so-called physicians draft law on October 16th. Much of this might have been avoided, it would appear, if ALL physicians under the age of 50 had been called upon to register at this one time. Separation of those holding reserve commissions would have been merely a matter of checking the records. The greatest confusion appears to exist over the status of many World War II medical officers who are uncertain as to whether they still hold commissions.

The Office of the Surgeon General of the Army has stated: "Reserve officer appointments or reappointments in force at the outbreak of World War II (or made subsequently) remain in force until six months after termination of war or termination of the five-year appointment period, whichever is the later, unless specific action to terminate the appointment has been taken by the Department of the Army. Under current law in this instance, World War II has not been declared terminated." The status of those medical officers holding AUS commissions has not been clarified insofar as The Journal is aware but general opinion holds to the belief that such officers cannot be recalled to active duty under AUS commissions.

The Bureau of Naval Personnel states: "A man is still in the Naval reserves unless: 1. He has resigned his reserve commission, or 2. He has been discharged from the reserves. The mere release to inactive duty of an officer in the Naval Reserves does not sever his connection with the Navy."

Air Force has no separate medical service during World War II. The Air Surgeon's Office has stated that the foregoing Army statement would apply.

Both services emphasize that this information is for guidance, not for determination of status. The physician, uncertain of his status, should request authoritative information on his own situation from his Military District commanding officer or Naval District commandant.

Official status as an advisory group to Selective Service in Arkansas has been given the Procurement and Assignment Committee formed by the Society in September. This committee will now apparently be designated as the Health Resources Advisory Committee of the National Security Resources Board. Dr. Fount Richardson, Fayetteville, heads this committee which includes, in the state group, a dentist and a veterinarian. The following statement is an exact quotation from a statement by the Secretary of Defense on November 26, 1948, as printed in the Selective Service System Local Board Memorandum No. 6, as amended January 7th, 1949. This statement is the current authority regarding which physicians are eligible for the $100 per month pay bonus:

"Reserve commissions are now available in the Medical Corps and Dental Corps of the Army and Navy to doctors of medicine and doctors of dentistry who have the proper professional qualifications and are physically and otherwise qualified. Persons who volunteer for these commissions and are placed on active duty before being inducted under the Selective Service Act

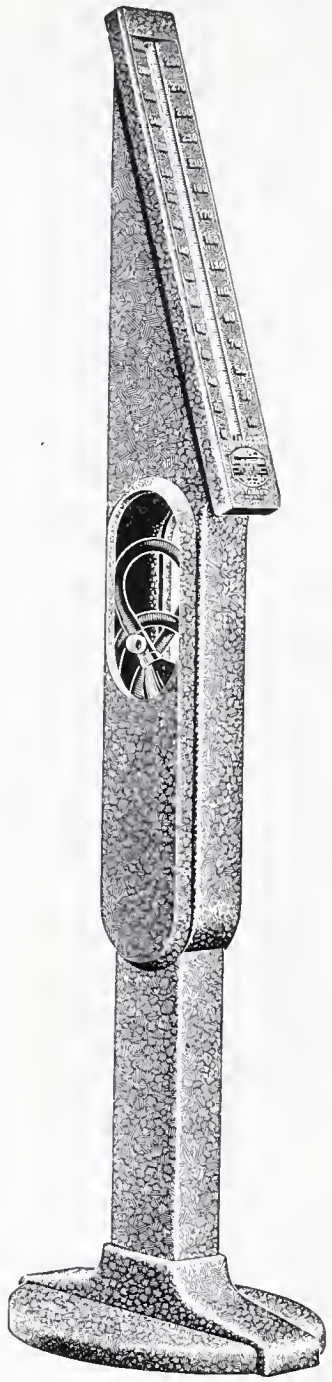
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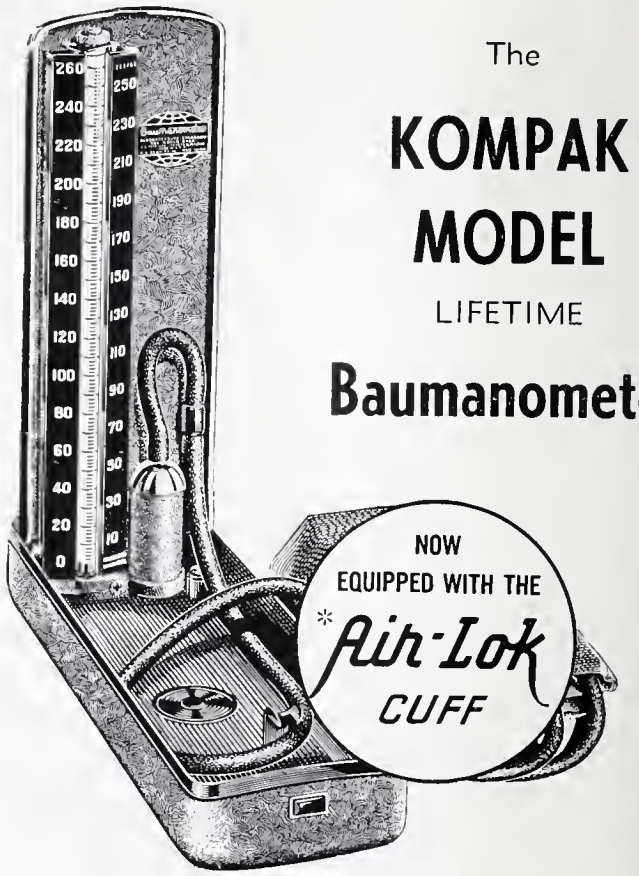
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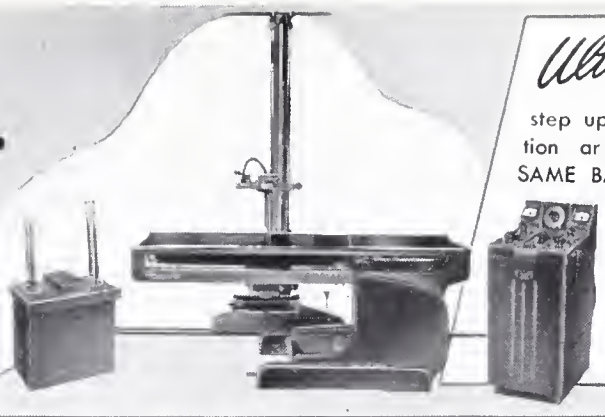
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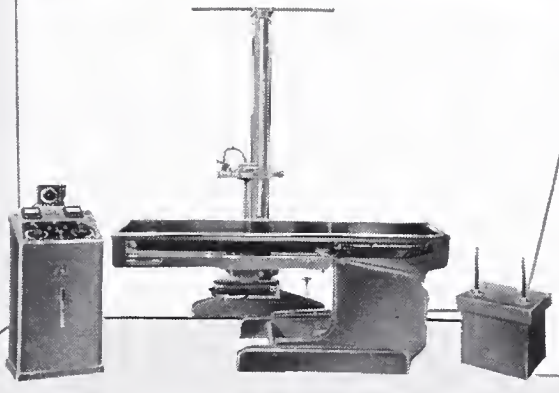
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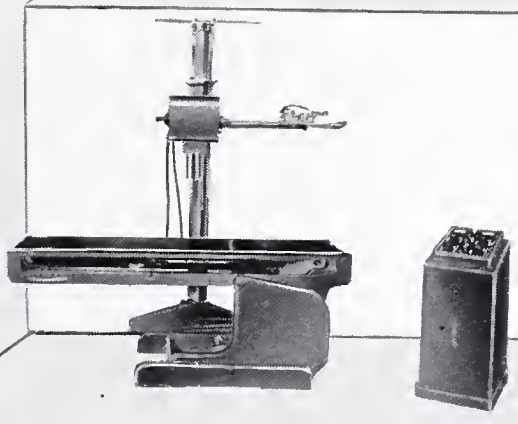
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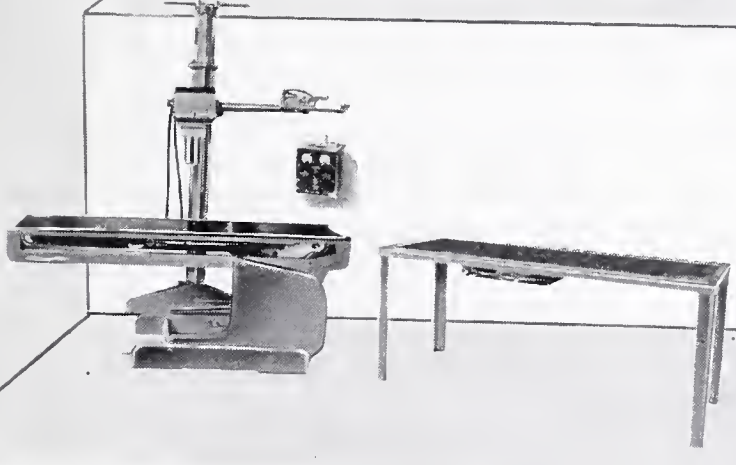
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are entitled to receive the $100 per month additional compensation authorized by Congress for doctors and dentists who enter the services under the voluntary plan. This extra compensation is not available to persons who enter the services through Selective Service, even though they are subsequently commissioned.

"These reserve commissions are available to qualified doctors of medicine and dentistry who have completed a four-year medical or dental course and are now serving their internship, as well as those who are about to start their internship. Once accepted and commissioned in the reserve they may be called for a period of active duty in the Army, Navy or Air Force after they have finished their current year of training. The acceptance of such a reserve commission, while not of itself constituting deferment from Selective Service, is evidence of the individual's willingness to serve where the Armed Forces can best use him and may be presented to the local board in support of a request for deferment."

EDITORIAL COMMENT

DETAIL MEN

How do you treat these patient men whose days are a round of sitting in reception rooms awaiting the opportunity of calling attention to the products they are paid to represent? Products, we might add, almost always meritorious, and deserving of consideration by all physicians. Receive the representative with the dignity to which his calling entitles him; he is in a position to serve medicine well.

OBITUARY

CHARLES KENNARD TOWNSEND, age 60 years, died September 20th after a cerebral hemorrhage suffered while attending a meeting of the Tri-County Medical Society. Born at Black Rock, Arkansas, he graduated from Ouachita College in 1909 and from Tulane University of Louisiana in 1915. His internship of three years was served at Charity Hospital, Shreveport, and at Touro Infirmary, New Orleans. During World War I he served in the Army Medical Corps and upon his return joined his father, the late N. R. Townsend in practice at Arkadelphia, founding the Townsend Hospital. He was a member of Phi Beta Pi, Alpha Omega Alpha and Pi Kappa Alpha fraternities, a past-president of the Arkadelphia Rotary Club, a deacon in the First Baptist Church, physician to Ouachita College, a member of the Country Club of Hot Springs National Park and a member and past-president of the Clark County Medical Society, The Tri-County Medical Society and a fellow of the American Medical Association. Surviving relatives are his wife, a daughter, his mother and a brother, Dr. Ernest W. Townsend.

MELVIN K. BOTTORFF, age 44, Lake Village, died September 26th. Born in Little Rock, he graduated from the University of Arkansas School of Medicine in 1932 and had practiced in Lake Village since graduation except for time served in the Army Medical Corps during World War II. He was a member of the Masonic Lodge, the Southern Medical Association, a fellow of the American Medical Association, a member of the Phi Chi medical fraternity and of the Lake Village Presbyterian Church and a councilman of the City of Lake Village. Surviving relatives are his wife, two daughters and a son.

JOEL C. LAND, age 77 years, Walnut Ridge, died October 3rd after an illness of three weeks' duration. Born in Randolph County, he graduated from the Memphis Hospital Medical College in 1900 and was a registered pharmacist. He was a member and past-president of the Lawrence County Medical Society and had served as its delegate to the Arkansas Medical Society for many years; member and past-president of the First Councilor District Medical Society; member and past vice-president of the Arkansas Medical Society, member of the Southern Medical Association and of the American Association of Railway Surgeons and fellow of the American Medical Association. He had served as local surgeon for the Frisco and Missouri Pacific railroads for many years. He was a member of the Woodmen of the World, the Order of the Eastern Star and of the Masonic bodies including the Scottish Rite Consistory and the Scimitar Temple, A.A.O.N.M.S. He served as captain in the Army Medical Corps during World War I. Surviving relatives are his wife and three sons.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

FATE has challenged physicians in a peculiar way with respect to primary cancer of the lung. Of all internal cancers, those originating in the lung should be the most readily discovered while still locally confined. Not only can the lesions be found but they can be properly labeled. Excision of the cancer-bearing lung has been shown to be feasible, relatively safe and effective. Physicians, therefore, have the tools with which to find, label, and successfully treat cancer in this location.

SILENT PHASE OF CANCER OF THE LUNG

Cure of cancer of the lung was never seriously considered prior to 1933, when total excision of the lung was shown to be possible. During subsequent years, correlated studies of symptoms, roentgenographic shadows, bronchoscopic observations, cellular elements of sputum and surgically detected pathologic conditions have been made. Much is now known as to the life history, direction of spread and variabilities of the several histologic types of cancer of the lung. Sufficient time has elapsed to find from the literature a mounting list of recorded five year cures. It has been shown that cure rates are high if the patients submit to pneumonectomy at a time when there is no demonstrable growth outside the lung. Those patients who were saved by pneumonectomy have been able to enjoy life and have taken a productive position in society.

Since cancers are growths, all extensive lesions were at one time small and localized. To eliminate all delay in the discovery of any cancer is, of course, essential. The average patient waits three months after the onset of symptoms before seeking advice. The record then shows that, by the orthodox methods physicians use to sort out patients with cancer of the lung from those with other conditions, there is another seven months' delay.

Why has the time schedule been so prolonged? There are four principal reasons:

1. The first and only symptom is usually nothing more than cough.

2. The stethoscope is unreliable because abnormal physical signs are either nonexistent or the same as those encountered with any common chest ailment.

3. Secondary infection is frequent during the symptoms phase and becomes a "red herring" leading to misdiagnosis and misdirected treatment, usually for recurring colds, chronic bronchitis, or virus pneumonia.

4. Abnormal areas of density in the conventional roentgenogram of the chest are extremely variable because of bronchial occlusion of the segmental or subsegmental bronchi. The anatomic arrangement of the pulmonary segments permits a wide range of possible shadows, depending on the relative position and superimposition of the aerated to unaerated segments.

Since the orthodox method of case finding depends on a lesion extensive enough to produce symptoms, and since the signs are so variable and confusing, it is obvious that delays in definitive treatment are bound to occur. The same situation developed in regard to case findings in tuberculosis. By depending on a warning symptom, visits to the physician, therapeutic trials and eventually the true diagnosis, the disease in about 85 per cent of all persons with tuberculosis had progressed to advanced stages. Case finding of the presymptomatic or silent lesion by the mass survey method has reversed the ratio of minimal to advanced cases, and a yield of 85 per cent of minimal cases are discovered.

Detectability of Cancer of the Lung

Cancer of the lung has a silent phase and is detectable. The air within the expanded lung provides a natural contrast medium for the detection of changes in density. Small tumors growing in the periphery will cast a direct shadow. Smaller tumors centrally located cause a subsegmental or segmental bronchial obstruction, which will cast a shadow of the corresponding atelectatic segment. An airless segment will cast a shadow many times the size of the shadow

of the tumor itself; thus there is actual magnification of centrally placed lesions which represent the great majority of all pulmonary cancer. This is fortunate, as small tumors within the pulmonary hilus might otherwise escape detection because of the growing of normal bronchial and vascular shadows in this area.

The case-finding program in tuberculosis is already performing a double service as the incidental finding of silent cancer has shown. Patients with suspicious abnormal areas of density apparent in a survey film have been observed; on exploratory operation these densities sometimes prove to be cancer. Although the discovery of cancer in tuberculosis survey programs has not produced startling figures, the follow-up of all suspect cases has been incomplete.

The Length of the Silent Phase

Rates of cancer growth vary, but there are isolated instances in which abnormal shadows existed for several years and yet on surgical exploration the lesion was found to be apparently localized. Exploratory operations also have been known to reveal extensive metastases. This in no way mitigates the value of screening unless recent roentgenograms were normal. If the survey roentgenogram represents the first and only roentgenogram the patient ever had taken, who will deny that, if the person had been having annual examinations previously, cancer in an operable stage probably could have been discovered. It is impossible to say how often patients should be screened in order to give reasonable protection from cancer of the lung. As further experience develops, this point can be determined. For the present, selective screening on an annual basis would seem to be wise. The highest yield will be among men over 45 years of age.

Need for Proper Labeling

Screening the whole population and spotting abnormal pulmonary densities is the first step. Prompt and adequate investigation of suspects is equally important. Additional information can be obtained by: positional, stereoscopic, tomographic roentgenologic studies, cytologic examination of sputum, bronchoscopy, and exploratory thoracotomy. Negative sputum or negative bronchoscopic examination does not prove the nonexistence of cancer. If the abnormal roentgenologic density cannot be explained with reasonable certainty on any other basis, surgical exploration should be advised. Fortunately, today this can be done with safety. With the chest open and the lung under direct inspection and palpation, the lesion which caused the abnormal shadow can be readily located. Lesions near the surface and many in the hilar area can be directly biopsied. If the lesion is located centrally, within a segment or subsegment, and direct biopsy is considered not to be technically easy, then the segment or subsegment bearing the mass should be removed. The best cancer operation, here as elsewhere, is one which follows the principle of the widest possible excision of the cancer-bearing organ with all the regional lymphatic vessels.

Conclusions

(a) Orthodox methods of case finding based on symptoms have produced a low yield of localized pulmonary cancers. (b) A silent phase of cancer of the lung exists and is detectable by periodic radiologic screening. Survey methods developed for tuberculosis case-finding may do a double service. The highest yield of silent cancer will be found in the male population of 45 years and over. (c) The labeling of survey-found abnormalities must be prompt and exact. Although time lags in tuberculosis follow-up may not prove to be fatal, time lags may cost patients their lives if cancer occurs. (d) Surgical exploration in cases in which cancer is suspected will establish the exact diagnosis and will permit immediate excisional therapy, which for most will be curative.

Silent Phase of Cancer of the Lung, Richard H. Overholt, M.D. and Ivan C. Schmidt, M.D., J.A.M.A., Nov. 19, 1949.

RESOLUTION

BENTON COUNTY TUBERCULOSIS ASSOCIATION

Bentonville, Arkansas

RESOLVED—That in recognition of the long and faithful service of Dr. George M. Love as President of the Benton County Tuberculosis Association and his services as Director of the Arkansas Tuberculosis Association, that he be made HONORARY PRESIDENT FOR LIFE of the Benton County Tuberculosis Association.

Be it further resolved that a copy of this resolution be sent to Dr. George M. Love. A copy shall be sent to the press and a copy to the Arkansas Medical Society.

(Signed) Dr. Kenneth A. Siler, 1st Vice Pres.
(Mrs.) Ruth Moody, Secretary.

PROCEEDINGS OF SOCIETIES

W. E. Berry, Jonesboro, addressed the Lawrence County Medical Society at Black Rock September 12th on medical manpower requirements of civilian and military services.

The Arkansas State Radiological Society met in quarterly luncheon session at Little Rock October 1st.

Lawrence County Medical Society met in dinner session at Imboden on October 10 to honor Charles D. Tibbels, Black Rock, who was presented with the Fifty-Year Club award.

RANDOM THOUGHTS OF THE SECRETARY

September 23rd. It is a complete defeat week for us: the high school, Saint Anne's Academy, the local Negro high school and the Porkers.

September 27th. Strangely cast for the part but present this morning as bids are opened for new construction at Saint Edwards Hospital, our first time for an occasion of this sort, quite a bit of excitement for those to whom contracts may be awarded.

September 28th. En route Saint Louis, the Dormans vacation bound, board the train at Springdale with the Dorman youth taking complete charge of the Pullman.

September 29th. Breakfasting with the Dormans, a gay group intent on the Cardinals game and the zoo, that is, the younger duo. With the American Roentgen Ray Society celebrating its fiftieth anniversary in goodly attendance and homeward tonight.

September 30th. Dining at the Lido tonight where are observed the Hollenberg-Cooper-Jones group and the Hoyt Allens, enjoying better food in Little Rock amidst pleasant surroundings.

October 1st. Meeting with the state radiological group in business session and departing to sit in on the closing moments of the (EMC) committee struggling, as from its inception, to arouse an interest on the part of physicians against the trends of socialism.

October 3rd. With no consideration of the problems which might ensue we gladly accept Bob Watson's invitation to ride to Fayetteville tonight, having our first suspicion when he arrives with a malfunctioning carburetor and a loose motor support but away in good style and conversation until the gas supply exhausts itself just two miles south of Mount Gayler. Fortunately, the Burns' pass by and relieve us of the long walk we had volunteered and on to Fayetteville only 30 minutes late where Bob gives forth with an excellent presentation.

October 5th. Again to Fayetteville, this time in the new Chevrolet and much more slowly than is our custom, visiting Howell Leming's place before our return and finding him busy with the problems of practice.

October 8th. Visiting Bill who proudly escorts us about Washington and Lee campus and we tour the adjacent Shenandoah Valley including Natural Bridge and the long walk up Cedar Creek to Lost River, a happy day indeed.

October 9th. Arising at 4:30 A. M. to work our way back from the Blue Ridges of Virginia to the Ozarks of Arkansas, attending the Medical Society of Virginia where the question of membership according to the Democratic party pattern arises, is defeated, and we conclude a rather busy day but one well worth its minor discomforts, on the home town airport at 5 P. M.

FOR SERVICE RENDERED

This is no report on a "servant of the people" in the usual sense of the expression. It's not about a governor or a cop on the beat.

This is a man who has rendered service in its truest and finest meaning.

There's been a shadow of gloom around the Gazette city room this week. Our doctor-friend, who went from North Africa through the Battle of the Bulge, is going back to war.

He has treated quite a few of us and been as considerate of our imagined ailments as of our real ones. We have known him in his office and outside it, and in both places he has lived up to every ideal we have assumed about the medical profession.

He has knowledge, ethics, compassion, strength and gentility. Humanity is not just a work to him.

Mothers whose sons are in uniform can be happy there will be at least one such man in the Medical Corps. If there is a way of going good for their boys, he will find it.

Doctors, beating their breasts against socialized medicine, should look to the ways of our friend if they want to destroy state medicine. His fight against socialization of his profession is an effective one because he's fighting it at the grass roots by deeds instead of lip service.

Incidentally, he answered his recall to the service of his country with considerable aplomb and right good cheerfulness for a man who is sacrificing much financially and emotionally. He recognized it as an obligation of his Hippocratic oath.

We know of his many charities—but not from him. His real concern is for the sick, not for shooting the course in par on Sunday afternoon. We know doctors who seek publicity like a Hollywood starlet—but if we put the name of our friend in the paper, he might not be our friend no longer.

The knowledge that he will come back after his "21 months" of duty is completed is small comfort to us now.

We don't know what to do for him before he leaves. We know of no other way to pay tribute except by this piece, the product of our trade. We know he will read it and maybe realize the depth of our respect.—M.T., S.G.H., C.B.M., A.R.N.

—Arkansas Gazette.

PERSONALS AND NEWS ITEMS

Born—On October 10th, John Andrew Agar to Dr. and Mrs. Drew Agar, Little Rock.

W. G. Cooper has been elected a member of the Little Rock School Board.

John McCullough Smith recently addressed the Little Rock Optimist Club.

Dr. and Mrs. Hoyt R. Allen, Little Rock, spent a recent vacation in Virginia.

L. K. Hundley has been elected a member of the Jefferson County School Board.

In attendance at the recent regional meeting of the American College of Physicians at Tulsa were: A. A. Blair, Chas. T. Chamberlain, Art B. Martin and J. Ken Thompson, Fort Smith; E. Driver Rowland and Frank M. Adams, Hot Springs National Park; H. E. Leming, Fayetteville; Dan H. Autry, Jerome S. Levy, Paul A. Day, Ben Wells, J. N. Compton, R. E. McLochlin, Al Kahn and O. C. Melson, Little Rock, and Stewart M. Wilson, Rogers.

Among those registered at the Denver session of the Southwestern Surgical Congress were: L. H. Good, Texarkana; S. W. Hawkins, John D. Olson, M. B. Hoge, Fort Smith; J. Harry Hayes, S. B. Thompson, Little Rock; John H. Wilson, Magnolia; Jeff Baggett, Prairie Grove, and W. E. Knight, Fort Smith.

The following have been elected surgeons of their respective American Legion posts: H. H. Buckelew, Rogers; H. B. Wright, Waldron, and H. A. Dew, Warren.

Lamar McMillan, Little Rock, spent a recent vacation in Venezuela.

Dr. and Mrs. John W. Dorman, Springdale, spent a recent vacation in Saint Louis.

"Traumatic Avulsion of the Skin of the Shaft of the Penis and Scrotum," by Ellery C. Gay and Gordon P. Oates, Little Rock, appeared in The Southern Surgeon, September, 1950.

Paul H. Woods has moved to 875 Park Avenue in Hot Springs National Park.

Gilbert O. Dean, Little Rock, addressed The Dallas Postgraduate Conference during October on "Principles in Opening and Closing the Abdomen," "Causes for Failure in Biliary Tract Surgery," "Femoral Hernias" and "Chest Injuries."

In attendance at the South Central section, American Urological Association, Tulsa, were Grady Reagan, John N. Roberts, Watt Reagan, Little Rock, and Carl L. Wilson, Fort Smith. Watt Reagan presented a paper: "Arteriography as Observed in 80 Patients at Saint Louis City Hospital."

Marion S. Craig, Little Rock, addressed the Louisiana Academy of General Practice at Shreveport September 29th on "The Management of Pruritus Ani."

WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary to the Sebastian County Medical Society held a luncheon meeting October 9 at the McCartney House. Mrs. W. L. Shippey, President, presided.

The President briefly outlined the program for the year. She explained the point system set up by the State Auxiliary for county auxiliaries.

Mrs. Fred Krock, Legislative Committee Chairman, reported that work was progressing on the by-laws.

Mrs. Louis Whittaker, Public Relations Committee Chairman, reported that the Auxiliary sponsored a booth at the Arkansas-Oklahoma Livestock Exposition in Fort Smith, during the week of September 24.

Mrs. Whittaker also reported that local radio stations had been contacted and that arrangements are being made to broadcast the various transcriptions and programs furnished by the American Medical Association.

Mrs. Kenneth Thompson, Vice-President, reported for the Publicity Committee, explaining the various methods of receiving points for publicity.

It was voted to donate $5 to the Erle Chambers Memorial Fund, $5 to the Jane Todd Crawford Student Loan Fund and $10 to the Ilse F. Oates Student Loan Fund.

Yearly subscriptions to **Today's Health** are again being sent to the Y.W.C.A., Wildcat Sanatorium, State Sanatorium, Rosalie Tilles Children's Home, Carnegie Library, and the Girls Club.

Mrs. J. Kenneth Thompson,
Vice-President.



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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

BOOK REVIEW

Dr. Colwell's Daily Log for Physicians. Champaign, Illinois: Colwell Publishing Company.

The most complete and efficient business record system for the individual physician available, a compact volume with space for every needed item.

Pathologic Physiology: Mechanisms of Disease: Edited by William A. Sodeman, M.D., F.A.C.P. The Wm. Henderson Professor of the Prevention of Tropical and Semi-Tropical Diseases, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana; Consultant in Medicine, U. S. Marine Hospital at New Orleans. 808 pages with 146 figures and 30 tables. Philadelphia and London: W. B. Saunders Company, 1950. Price $11.50.

This very fine compilation of 25 authors edited by Wm. Sodeman sets out to analyze medical problems from the standpoint of "disturbed" pathologic physiology. Attempts to do this through a study of the mechanisms back of the patient's signs and symptoms. It is a very dynamic book and one which every beginning student of disease and every general practitioner should read. It is very much up to the minute on all aspects discussed, the contributors are all recognized current authorities in their respective fields.

The early chapters are devoted to the functional aspects of cardiovascular disease. Not only are standard approaches to problems discussed but each author's own experimental contributions are inserted. This is followed by chapters on the respiratory, digestive, and urinary systems. The endocrine glands are thoroughly discussed as is water balance and nutrition. It is pleasing to see the importance placed upon the proteins and protein deficiency in diet. In line with current trends there is much on the locomotor system, particularly the joints and synovial membranes. Ideas current in the arthritis field are discussed. There are five chapters on infectious diseases and two chapters on physical, toxic and chemical agents conclude the work. These latter chapters are of extreme importance in a world which is so war minded. They were written by Wm. Bean whose experience in this field derives directly from war work and who is perhaps more ably qualified to write on this subject than any other person.

Anyone expecting to find detailed treatment plans in this book will be disappointed. If he wishes to learn what current trends of thoughts are in physiology though he can ill afford to miss the book. After reading the book one concludes that although many general laws which attempt to express biological responses are herein written, the inherent complexity of the organism man and the variability of stimuli make this a near impossibility.



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The Journal of the Arkansas Medical Society

Vol. XLVII FORT SMITH, ARKANSAS, DECEMBER, 1950 No. 7

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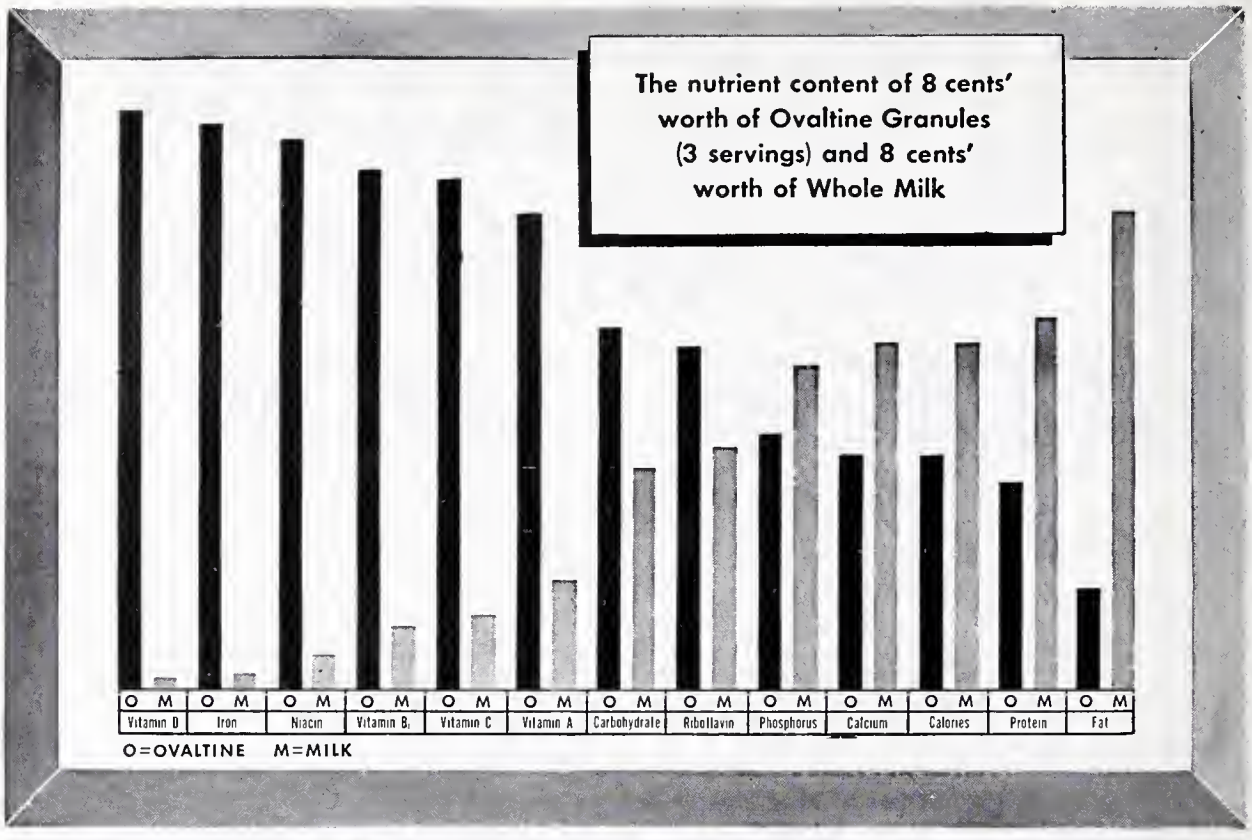
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A FANCY PACKAGE OF UNTRUTHS

ELMER L. HENDERSON, M.D.
Louisville, Ky.

The story of the creation of the world is told in Genesis in 400 words. The greatest of all moral codes — the Ten Commandments — contains only 297 words, and Lincoln used 266 words in his immortal Gettysburg address.

The CIO National Health Committee—whatever that is—used more than 1,000 words in a paid advertisement, appearing in a number of newspapers during the week of October 22, to tell doctors that it did not like the American Medical Association's national advertising campaign against socialized medicine. The advertisement, headed "Dear Doctor," evidently appeared in newspapers in cities where a CIO candidate is running for office on a platform to support the administration's compulsory health insurance plan. It appears to have the full support of the CIO, but one wonders how many members of this organization ever saw the advertisement before it was published or would support it when they did see it. The advertisement, which bitterly denounces the American Medical Association and nearly everything for which it stands, is the same old fancy-wrapped package of lies, untruths, half-truths and part-truths—all aimed at confusing the American people on the issue of socialized medicine. It really reveals the ruthless boldness of the men who are spreading this cancerous growth of socialism among the people.

Dr. L. Fernald Foster, secretary of the Michigan State Medical Society, ably answered the advertisement in a 15 minute radio broadcast in Detroit. In an address over station WJR, Dr. Foster said, "Unfortunately for scientific medicine and perhaps unfortunately for your future health, doctors of medicine are not propagandists. They do not know the art of the 'Big Lie' which I am told, if repeated often enough, becomes accepted as truth. They do not practice the art of spreading malicious rumor. . . . The medical profession of Michigan — and throughout the United States—is fighting mad today and is assuming a militant attitude against the purveyors of malicious lies. The profession has no quarrel with Mr. Taxpayer. It is angered because your tax money is being used freely by the propagandists to spread brutal falsehoods which hurt you and your chances for continued good health."

In reading the advertisement, the public naturally did not know that nearly the entire text was taken from a speech which Representative Andrew J. Biemiller, Democratic representative from Milwaukee, made before Congress and which appeared in the August 30 issue of the Congressional Record. Congressman Biemiller, as we all know, has sung the praises of socialized medicine for a long time; yet, in 1937 and again in 1939, he failed to sell such a scheme to the people of Wisconsin. He once managed the Midwest campaign of Norman Thomas, a Socialist candidate for President, and a Republican officeholder referred to him during the present campaign as "the man who came sailing out of Eastern universities to Wisconsin as the socialist educational director for Milwaukee County." In a sense, therefore, the advertisement was written by Congressman Biemiller, who gave the American Medical Association a lashing on several points, saying the Association and its state and local medical societies: Opposed vaccination against diphtheria and other contagious diseases by public health authorities; fought against the reporting of communicable diseases and public health services to control tuberculosis and they still oppose free diagnostic centers for tuberculosis and cancer; fought against setting up free venereal disease clinics; fought workmen's compensation laws; fought group medical practice; fought the American Red Cross blood bank plan; fought voluntary insurance plans, and fought many other projects.

His charges are outright lies. Neither he nor those responsible for preparing the advertisement took the time or trouble to ascertain the truth. Evidently, the propagandists had only one objective in mind: to fool the American people. The truth of the matter is that the House of Dele-

gates, the policy-making body of the American Medical Association, never opposed vaccination against diphtheria or against any other contagious disease. And it never fought against the reporting of communicable diseases and public health services to control tuberculosis. In fact, the House in 1925 urged periodic health examinations for the general public, and in 1937 it adopted a resolution urging that "every effort be made to promote all features of preventive medicine, including diphtheria and all communicable diseases, and to make these features available to the public." That certainly does not smack of opposition.

In his wild reference pertaining to cancer and tuberculosis control, Mr. Biemiller did not trouble himself to check the resolution, passed by the House back in 1905, which commended the "American Society for the Control of Cancer" for its program of public education on detection and prevention of cancer. Nor did he bother to delve into the fine work which the Woman's Auxiliary to the American Medical Association has done since its founding in 1922 to prevent and eradicate tuberculosis, especially among children. His comments about venereal disease clinics are ridiculous. In 1937—13 years ago—the House adopted a resolution recommending special venereal disease divisions in health departments and use of hospital and dispensary clinics for early treatment and follow-up.

It might interest Mr. Biemiller to know that the Association never opposed the principle of workmen's compensation legislation. Any statement to that effect is a deliberate untruth, aimed to mislead the American working man. During the formative period of this legislation, the American Medical Association did contend that there were certain inadequate provisions for the supplying of medical care to injured workmen, and pointed particularly to the absence of any right given to the injured workman to select his own physician. That stand of the Association was to protect the working man and not to challenge any benefits he might receive. As Dr. William D. Haggard, president-elect of the Association in 1925 said, "The denial of the right of the patient to choose his own physician or surgeon when injured in un-American, unwise and one step toward state medicine."

Mr. Biemiller said, too, that the American Medical Association fought group practice. The statement actually is silly, because three Mayo Clinic physicians have served as presidents of the Association, and at least three members of its Board of Trustees are connected with such clinics. Dr. William Mayo served as president in 1906, Dr. Charles Mayo in 1916 and Dr. E. Starr Judd in 1931. All three were connected with the best known group practice clinic in the world. The American Medical Association has consistently fought for the highest type of standards in group practice. When any group practice plan was tied in with a questionable insurance scheme or when a patient was restricted to a particular group of doctors by his insurance policy or when any group practice plan restricted a patient in the free choice of a physician, the Association was never hesitant in voicing bitter objection. This was done in the sole interest of better medical care for the patient. The attitude of the American Medical Association toward group practice is plainly revealed in a section of its "Principles of Medical Ethics," which says, "The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual."

Mr. Biemiller made his caustic reference to the American Medical Association and the American Red Cross Blood Bank plan even though the American Medical Association's House of Delegates had gone on record as endorsing the idea of a national blood procurement program under under auspices of the Red Cross. Furthermore, when the Red Cross Blood Bank plan was first conceived — even before it was publicly announced—the Board of Trustees of the American Medical Association approved it in principle. If Mr. Biemiller had investigated first, he would have learned also that the Association, at considerable cost to member doctors, made the only comprehensive survey of blood banking in the United States.

For Mr. Biemiller to imply that the American Medical Association opposed voluntary health insurance plans of the type available today is a deliberate falsification of facts. Fifteen years ago, the Association did oppose some of the so-called voluntary health plans, but for good reason. Certain features were objectionable, and they have long since been eliminated, thereby helping to speed up the growth of the strong voluntary health plans as they exist today. Today, the total number of persons protected by all types of hospitalization and medical care insurance exceeds 70,000,000, a remarkable figure when one considers that the total only five years ago was 26,000,000.

Mr. Biemiller said, too, that the American

Medical Association "blocked federal aid to medical schools." He is right, but he failed to explain that the bills proposed would lead to control of the medical schools by the federal government either directly or indirectly with a gradual deterioration of medical education because of political domination. The Association long has held that the problem of financial support for medical schools should be freely in the hands of the communities or states served by these schools.

The advertisement inspired by Mr. Biemiller's speech said that, since "the cost of medical care is too high for anyone except the wealthy, the people want to pool their resources to meet a common risk." What the advertisement failed to tell union men is that under whatever methed a worker's medical care is paid, he himself eventually will have to pay the bill.

If the bill comes from Uncle Sam, it will be a tax bill and there will be no escaping it. It will be a stiff bill, too, because it will have added to it all the lost motion, waste and inefficiency that goes with government management in any big business. Added to the worker's medical costs will be the salaries and maintenance of administrators, accountants and supervising physicians, as well as the costs of accounting machinery and the necessary buildings to house the records. The worker certainly will be subject to all the disadvantages of deteriorating medical care at a high price.

By placing such an advertisement in newspapers, those responsible for it showed that they have lost all sense of fair play. As a union, the CIO believes that every member has a right to have something to say about the conditions under which he works. Doctors have as much right as the coal miner, the steel worker, the railroad man or any other person to have a voice in determining the conditions under which they work. They, as Dr. W. W. Bauer said in his recently published book, "Santa Claus, M.D.," especially are entitled to this privilege because of the safeguards their profession believes is necessary for the welfare of the patient. Yet, through what is advocated in the advertisement, impossible conditions would be imposed on the 200,674 physicians in the United States. This is dishonest, unfair and contrary to all American principles and contrary to what members of a union themselves fight for.—Journal of the American Medical Association, November 11, 1950.

INFECTIOUS MONONUCLEOSIS

By G. HARRISON BUTLER, M. D.,
W. J. BUTT, M. D.,
and
FOUNT RICHARDSON, M. D.
Fayetteville

Infectious mononucleosis is not a new disease, but has been known for many years under various terms. It was first described in 1889 by E. Pfeiffer (1) who called it "drusenfieber" a condition epidemic in children and characterized by malaise, fever, glandular enlargement of the cervical region, nonsuppurative sore throat, hepatomegaly and splenomegaly. Sprunt and Evans (1) reported adult cases in 1920, and in 1921 Tidy and Morely (1) suggested that the adult and juvenile types were manifestations of the same disease. Others have used the synonyms "glandular fever" or "benign lymphadenosis" for it.

Musser (1) defined the disease as "an acute contagious disease of the reticulo-endothelial system characterized by glandular enlargement, fever, hepatomegaly, splenomegaly, increase of the mononuclear cells and symptoms of constitutional debilitation." Houck (2) has divided the history of this disease into four periods: The first period was that of clinical description which opened in the late eighteen eighties and terminated with the discovery of the blood changes in 1920. The second period was from 1920 to 1932 during which time the hematologists dominated the picture. The third period began in 1932 when Paul and Bunnell (3) discovered that sheep cells were agglutinated in the serum of a patient with infectious mononucleosis. Bailey, Raffel (4) and Davidsohn (5) devised the absorption tests used in conjunction with the Paul-Bunnell test which increased the accuracy of diagnoses. The fourth period beginning in 1944 may be called the period of pathological description based upon a total of ten autopsy studies.

The pathology of Infectious Mononucleosis is now clear. The basic lesion is a perivascular infiltration of both normal and abnormal lymphocytes which is found in all tissues except the bone marrow. The cells are believed to be metaplastic and to be formed from other cells of the reticuloendothelial system. The cells are not considered invasive. The lesion may persist long after the patient is judged to be well. This fundamental and characteristic lesion is not at all uniform in its distribution throughout the body and in any individual patient may be more marked in the central nervous system, in the liver, in the kidneys, or in the lungs. The renal infiltrations produce an inter-

stitial nephritis but are not known to cause permanent damage.

The etiology is not definitely known, but considerable evidence has been adduced to support the belief that a virus is the causative agent (6), (7).

There are several reasons for bringing this disease to your attention at this time. First, the disease is becoming more prevalent, or it is being recognized more commonly. Second, there are so many manifestations of the disease that it may be overlooked unless one is on guard; it is truly protean in its nature. If Osler were living today it is quite likely that he would amend his axiom to include infectious mononucleosis on an equal status with syphilis as one of the great imitators. Third, many cases are of such mild nature that the victims rarely seek medical attention or if they do consult a physician, frequently they are dismissed as having some minor illness of little or no consequence, or possibly they may be labeled as neurocirculatory asthenia or post influenzal asthenia or even plain neurotic. Fourth, many of you are the family physicians "back home" and will be required to counsel the families of students who become ill with this troublesome malady while they are away from home. Hence, we feel that it is proper to pass on some basic information as to our experiences, observations and thoughts relative to the condition, so that you may properly give advice as to the expected morbidity, etc.

During the calendar year 1949, the Student Health Service of the University of Arkansas saw approximately 208 patients in whom a diagnosis of infectious mononucleosis was established. In the same year the student enrollment for the regular session was approximately 5,000 with approximately 2,500 students enrolled for the summer term. This is a slightly higher percentage than was found in one year at the University of Michigan (8) where the disease was found in 273 individuals out of approximately 15,000 students for the twelve-month period. However, our incidence is comparable to that of other large colleges or universities in neighboring states, as well as the incidence found in our own private practices. During the same year thirty-eight patients required bed care because of this illness. Three of these thirty-eight were admitted twice. The shortest period of bed care was two days; the longest period in bed was fourteen days. One case required bed care for eight days on each of two occasions. The average number of days in bed was 5.8. One case was sent home for an entire semester. All of these thirty-eight cases were supervised for at least one semester after their initial period in bed.

Weschler, Rosenblum and Sills (9) have reported their findings in an epidemic of infectious mononucleosis which occurred during World War II. They found that the spleen, the cardiovascular system, the kidneys, the skin, the central nervous system and the liver were involved in various patients in their group. They stressed the fact, which agrees with our observations, that the disease is very prone to relapse.

In a general manner we have divided our patients into two groups. First, those with acute, severe symptoms which usually persist in the acute phase for a period of one or two weeks, but occasionally lasting as long as three or four weeks. The second general group is characterized by an insidious onset with only a low grade fever and mild to moderate constitutional symptoms.

We have observed that blondes are more likely to be more acutely ill and have persistent clinical symptoms than are brunettes. In our experience the disease is not fatal although several different observers have reported fatalities from it. The complications of the malady are legion (10), (11), (12), (13), (14), (15), however, the outstanding one in our series is hepatitis. This seems to be in agreement with numerous observers. We feel that a great majority of the patients who seek medical care because of the illness have symptoms and clinical evidence of hepatitis and that the severe constitutional symptoms, particularly the debilitation and fatigability, are due to disturbed liver function. Brown, Sims, White and Clifford (16) have reported a series of eighty-three cases of infectious mononucleosis in whom random tests of liver function were performed with abnormal values being obtained in seventy-five of the eighty-three patients.

Severe central nervous system involvement in infectious mononucleosis followed by recovery has been reported by Field (17). Dolgopol and Husson (18) report a case of infectious mononucleosis with neurologic complications which proved fatal. We have seen three patients who presented typical clinical and laboratory pictures of infectious mononucleosis in whom central nervous system symptoms predominated. One of these a female (S.M.) had had a diagnosis of multiple sclerosis, however, these symptoms completely subsided following recovery or remission from the mononucleosis. A second patient (D.Y.) had a typical papilloretinal edema which cleared completely without residuals upon recovery from the disease. A third patient in this group (J.T.) not only presented alarming symptoms of encephalitis but also had nephritis which was evidenced by changes in the specific gravity of the urine, red blood cells and casts in the urine sediment, albuminuria and associated

edema of the face and extremities and hypertension. At this time she shows no evidence of renal or central nervous system damage.

We believe that many individuals have the disease in such a mild form that it is recognized only in retrospect. The mode of onset may be sudden or insidious. In the sudden onset group, the usual notable symptoms are chills followed by rapid rise of fever to 104° or 105°, headaches, dizziness or faintness, irritability, fatigue, anorexia, sore throat, malaise and general weakness. Purpuric eruption and skin rashes simulating measles or scarlet fever were said to occur quite commonly in the epidemics following World War I, but we have observed skin lesions, not purpuric, in only a few rare instances and they were of minor importance. Goldbloom and Lieberson (19) reported one case of infectious mononucleosis with jaundice and thrombocytopenic purpura with rapid recovery. Frequently there are generalized body pains, especially in the abdomen and gastrointestinal tract region so that acute appendicitis cannot be eliminated easily. Some observers have reported frequent occurrence of joint pains but we have seen this in only one patient. More or less generalized lymphadenopathy has been present in practically all of our patients. The spleen has been palpable in some of our series, but considerably less than one-half of them. It is fair to state that the diagnosis in the individual case at present must be somewhat presumptive and based on clinical manifestations supported to a certain degree by information supplied by non-specific laboratory tests. The diagnosis is often difficult to establish and in some cases impossible except after a period of observation and after being alerted to the possibility of the existence of the disease. Occasionally there may be a leukopenia for a short time which is usually followed by a definite leukocytosis. The mononuclear cells and the cells of the lymphocytic series must be appreciably increased before we feel justified in confirming the diagnosis. The heterophile agglutination is usually, but not always, positive in a dilution of 1:112 or more. Frequently the blood serology is falsely positive for a short time. There is little or no anemia.

Treatment consists largely of good, general supportive care and symptomatic therapy. Maximum physical rest is most imperative. Those patients exhibiting symptoms of hepatic involvement should have a high carbohydrate, high protein and low fat diet. Penicillin in adequate dosage should be used to prevent or control secondary infections. Adrenal cortex extract tablets by mouth are very useful in combating fatigue and debilitation. We have used aureomycin in a limited number of these patients and while the results are very promising, the series is too small and insufficient time has elapsed since treatment to permit proper evaluation at this time.

In conclusion we suggest three thoughts for your consideration: First, infectious mononucleosis might well be considered in the differential diagnosis of any illness, showing lymphadenopathy with fever, whether marked or slight; fatigability and numerous non-specific constitutional symptoms—nor can it be wholly ignored when constitutional symptoms are specific. Second, while the laboratory is nearly always helpful and is frequently specific in diagnosis, in the absence of positive laboratory findings, the diagnosis is still, ultimately, a matter of clinical judgment. Third, infectious mononucleosis rarely subsides in a short period of time and usually persists in a mild or subclinical form with periods of remission and exacerbation for weeks, months or years.

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UNUSUAL MANIFESTATIONS OF INFECTIOUS MONONUCLEOSIS WITH A CASE REPORT*

CHARLES A. THOMPSON, M. D.

From the Department of Medicine
University of Arkansas School of Medicine
Little Rock, Arkansas

Infectious mononucleosis is usually considered a benign disease of unknown etiology. It may occur at any age, but is most commonly seen in children, adolescents, and young adults. The usual manifestations are sore throat, fever, cervical adenopathy, headache, malaise, and a palpable spleen. At some time during the course of the disease there is usually a lymphocytosis and a positive heterophile agglutination. Early there may be leukocytosis and later a leukopenia. Occasionally, the blood Wasserman and Kahn become positive during the disease.

Ordinarily, if kept in mind, the diagnosis is not a difficult one. Occasionally, infectious mononucleosis presents itself with unusual and misleading manifestations. These may be easily explained if one remembers that he is dealing with a generalized disease process involving most all organs of the body. Because of the low mortality rate, there has been a lack of pathological material for study. Splenic and lymph node pathology has been described in several isolated instances and a few autopsies have been reported. Recently, Custer and Smith (1) reported the largest series of autopsies to date and presented a detailed description of the essential gross and microscopic findings in each organ. In addition, over 100 lymph node biopsies and 25 bone marrow aspiration biopsies were included in the study. The cause of death in their nine cases were as follows: Spontaneous rupture of the spleen—four, Guillian-Barre's syndrome—two nasal pharyngeal hemorrhage—one, laryngeal edema—one, and a convalescent case dying in an airplane accident. A brief summary of the pathology in these cases is as follows: The lymph nodes showed follicular hyperplasia and occasionally a blurred pattern which resembled malignant lymphoma. The spleen showed lymphocytic infiltration of the capsule and trabeculae, the latter causing the organ liable to rupture. The lungs showed an interstitial type of pneumonitis in one case and in all cases a more or less marked exaggeration of the lymphocytes in the peribronchial and bronchial areas. The myocardium showed scattered small infiltrates of normal and abnormal lymphocytes. The liver showed capsular and periportal lymphocytic infiltration. The bone marrow was normal in all cases. Four cases showed evidence of a meningo-encephalitis. From such widespread dissemination of the disease process, one can readily understand why there may be marked variation in symptomatology.

That jaundice may be the presenting symptom or occur later in the course of the disease is a well-known fact, although this is not a frequent finding. The differential diagnosis between infectious mononucleosis with jaundice and infectious hepatitis may, at times, be exceedingly difficult. Contratto (2), in reporting 196 cases of infectious mononucleosis found that ten cases developed jaundice with a positive reaction of bile in the urine and normal colored stools. Peterson (3) found the incidence of jaundice to be 15% in a series of some 40 cases which he studied. Previously, it was felt that the jaundice was due to obstruction of the common bile duct by enlarged lymph nodes in this area, however, this idea has been generally discarded in favor of direct involvement of liver tissue.

While jaundice is not a frequent finding in infectious mononucleosis, it has been shown by several authors that hepatitis without jaundice is not uncommon (3), (4), (5). Evans (4) studied 19 consecutive cases of infectious mononucleosis without jaundice and showed abnormal liver function test in a large majority of the patients. 90% showed an abnormal cephalin cholesterol flocculation and 68% showed elevation of the thymol turbidity test. In a control group of severe upper respiratory infections, these tests were normal. Cohen and Lidman (5) performed liver function tests in 15 consecutive cases of infectious mononucleosis without jaundice. The thymol turbidity, bromsulfaline test, and alkaline phosphatase were used to determine hepatic involvement. 100% of the cases showed abnormal results with the thymol turbidity and the bromsulfaline tests. An alkaline phosphatase was done in 8 of the patients and was found elevated in all of these cases. The authors feel that all patients showing abnormal liver function tests.

*The author wishes to express his appreciation to Dr. Oscar Gray for the privilege of reporting this case.

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should be treated in the same manner as acute infectious hepatitis. Using such measures as adequate bed-rest, high-protein, high-carbohydrate diet, and vitamin therapy, they were able to definitely decrease the morbidity.

Neurological manifestations may occasionally predominate the clinical picture of infectious mononucleosis. Bernstein (6), in his monograph written in 1940, lists three common presenting symptoms in central nervous system involvement: Headache, signs of meningeal irritation, and blurring of vision. Other symptoms, sometimes found, are cranial nerve palsies, cerebellar signs, and peripheral neuropathies. Although the neurological manifestations are usually mild, there has been a case reported in which the course was marked by continuous coma, frequent convulsions, motor aphasia and marked nyastagmus (7). Peters (8) and his associates have reported two fatal cases of Guillian-Barre syndrome associated with infectious mononucleosis. Both patients died in respiratory failure. The spinal fluid may or may not show pleocytosis, the predominating cell being the lymphocyte. The protein is usually elevated. It is generally accepted that infectious mononucleosis must be considered in the differential diagnosis of various types of lymphocytic meningitis, encephalitis, poliomyelitis, polyneuritis, and the Guillian-Barre syndrome (8).

Probably the rarest manifestation of infectious mononucleosis is thrombocytopenia purpura. There have been seven such cases reported in the literature (6), (9), (10), (11), (12), (13), (14). Because this unusual manifestation may be easily confused with leukemia, the correct diagnosis becomes extremely important. Read and Helwig (15) suggest that thrombopenia may be found more frequently if platelet counts were done in all cases in which petechiae were encountered. The etiology of the lowered platelet count is not known. Bethell and his co-workers (16) have suggested that this manifestation may be due to the previous administration of sulfa drugs to patients. Dameshek and Grassi (12) suggest that there may be a hypersplenism resulting in inhibitory action of the spleen on bone marrow activity. Read and Helwig (15) in their report of three cases of infectious mononucleosis with thrombocytopenia, leukopenia, and anemia, believe that this disease is an infectious granulomatous process which invades the bone marrow, as well as other organs, causing a depression of bone marrow activity.

The following case report is that of a 16-year-old boy with infectious mononucleosis complicated by thrombocytopenia purpura.

CASE REPORT

A 16-year-old white male entered the hospital with the chief complaint of nosebleed and purpuric spots over his lower extremities. The past history was non-contributory. He had not received any horse serum for several years.

The present illness began one week before admission when the patient developed symptoms of an acute coryza with excessive fatigue. Four days prior to admission he noticed a mild sore throat with the appearance of a small, slightly tender swelling in the left mid-cervical region. The following morning he developed a moderately severe nosebleed which occurred spontaneously. This was treated with an anterior nasal pack. Because of a low grade fever, he was given two grams of sulfadiazine that day. The next morning when he awoke he noticed multiple small petechiae on his lower extremities and oral mucosa with spontaneous bleeding from his gums. After a blood count revealed a high percentage of mononuclear cells and a paucity of platelets, the patient was sent to this hospital for diagnosis and treatment.

On admission, the blood pressure was 115/75, pulse 78, respiration 18, and temperature 99°. The patient did not appear acutely ill. Examination of the nose revealed evidence of recent hemorrhage. There were many pin-point petechiae in the oral mucosa with two ecchymotic placques on the lower lip. The oral pharynx was slightly injected and there was a diffuse non-tender swelling in the left mid-cervical region. The axillary lymph nodes were enlarged and non-tender. The spleen was easily palpable on inspiration. Both legs were covered with small petechiae. Examination of the urine revealed a 2+ albumin and numerous red blood cells microscopically. This was repeated three days later and showed a 4+ albumin with many red blood cells. Repeated blood examinations showed a normal red blood count and hemoglobin, a mild leukocytosis, a predominance of mononuclear cells in the differential count, and a decreased platelet count. (See Table 1.)

The initial impression in this case was acute lymphatic leukemia. It was suggested that a heterophile agglutination be done because the large mononuclear cells seen in the peripheral smear were characteristic of those described in infectious mononucleosis. These cells were large and atypical with vacuolated foamy cytoplasm. The heterophile agglutination test was reported as positive 1:448 and six days later 1:450.

The day after admission the patient developed a gross hematuria which persisted for one week.

His temperature was normal during his stay in the hospital except on two occasions when it rose to 101°. Treatment was entirely symptomatic. Ten days after admission the patient was discharged with no symptoms other than slight weakness. At this time, there were few petechiae remaining. He was feeling perfectly well and showed normal platelet counts when interviewed at intervals of two and six weeks after discharge.

SUMMARY

A brief review of the various unusual manifestations of infectious mononucleosis is presented including a summary of the pathology as reported in a recent article. A case of infectious mononucleosis with thrombocytopenic purpura is reported.

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TABLE I
STUDIES OF THE PERIPHERAL BLOOD

Date	Hemoglobin Grams 100cc	RBC	WBC	Platelet Count	Differential Polys	Lymphs
12-13-48	12.5	4.40	12,100	87,500	13	86
12-15-48	12.1	4.05	12,950	62,750	8	84
12-17-48	14	4.85	15,250	67,900	10	83
12-19-48	13.6	4.60	14,150	16,400	23	75
12-21-48	14	5.10	12,950	30,600	29	61
12-23-48	14.5	5.80	6,400	29,000	35	64
1- 1-49	14.5	4.80	9,600	216,000	48	42
1-30-49	14.3	4.90	8,300	244,000	56	40

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The fourteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 5-8, headquarters at the Municipal Auditorium.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include a panel discussion on ACTH and Cortisone, a series of talks on trauma and neoplastic disease, a review of the application of radioactive isotopes in medical practice, clinicopathologic conferences, round-table luncheon discussions and many other features of special interest.

Another attraction of the meeting will be daily demonstrations of medical and surgical procedures in color television. This program will be telecast from Charity Hospital to the auditorium and is sponsored by Smith, Kline & French Laboratories.

The Assembly has planned another interesting postclinical tour to follow the 1951 meeting in New Orleans. On Saturday, March 10, a party composed of doctors and their families will leave by plane for Panama. The itinerary also includes Medellin and Cali, Colombia; Quito, the capital of Ecuador and Lima, Peru. Medical programs and visits to hospitals have been arranged, together with a full schedule of sightseeing. The group will return to New Orleans on Sunday, March 25. Details and a complete itinerary are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

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EDITORIAL

HOSPITAL STANDARDIZATION

GEORGE F. LULL, M.D.

Since 1918 the American College of Surgeons, without assistance from other organizations, within the profession, has sponsored a hospital standardization program, the purpose of which was "to create in the hospital an environment which will assure the best possible care of the patient." It has been recognized by the medical profession and hospital group alike that the College of Surgeons through this program has made a significant contribution to American medicine and to the field of hospital administration as well. The cost of the program to date has been estimated at approximately $2,000,000, a financial burden which has been borne solely by fellows of the college.

Recently, the American College of Surgeons explored the possibility of conducting the program in cooperation with or by other interested organizations. The American Hospital Association expressed its interest in assuming responsibility for the program under its own aegis, and at its recent annual meeting in Atlantic City authorized an increase in dues of member hospitals for this purpose. A plan had been proposed which would create a 25 member commission within the American Hospital Association to include six members of the medical profession, six hospital administrators and 13 individuals with outstanding records as hospital trustees. The six-man medical committee was to have included three representatives of the American College of Surgeons and three of the American College of Physicians. To this committee was delegated the responsibility for formulating standards for those aspects of the hospitals' activities which were considered to be primarily of a professional nature. The determination as to which areas were primarily professional and which were administrative was, however, made the responsibility of the commission as a whole.

The American Medical Association, being of the opinion that a program of hospital standardization, such as had been proposed, would directly affect standards of medical practice in hospitals, requested that action by the American Hospital Association in establishing the standardization program be delayed until all aspects of the problem could be given careful consideration. Acting through its board of trustees, the association entered into discussion with the American College of Surgeons and the American Hospital Association in the hope that a cooperative plan could be developed which would eliminate a dual standardization program with its consequent duplication of effort and needless expenditure of funds.

The three groups have been holding meetings, the last of which was also attended by representatives of the American College of Physicians, in an attempt to clarify the position of the several organizations involved. Much progress has been made in working toward the objective, a plan in which the best interest of the public, the hospitals and the profession are all considered. There has been no disagreement over the principle that the setting of standards for the professional aspect of the hospital would lie with members of the medical profession. The American Medical Association has not felt, however, that this principle was adequately safeguarded under the plan originally proposed, which would set up a commission as an agency of the American Hospital Association.

As expressed in discussions held during the past several weeks, the American Medical Association is prepared at this time to consider favorably one of the following alternate plans:

1. Continued sponsorship of the hospital standardization program by the American Col-

lege of Surgeons, with financial support by the American Medical Association and other organizations directly concerned.

2. Establishment of an individual commission, board or committee, with representatives from the American College of Surgeons, American College of Physicians, American Hospital Association and the American Medical Association, which would be charged with the responsibility of formulating standards for administrative and professional aspects of hospital activities, for conducting a unified inspection program for approval of hospitals which meet these standards; the financing of the cost of the commission, including the field inspecting service, would be borne on a proportionate basis by member organizations.

3. Transfer of the standardization program to the Council on Medical Education and Hospitals of the American Medical Association, with a unified inspection program conducted in connection with the field service now administered by the council in the approval of hospitals for intern and resident training. (In general surgery the council presently conducts hospital surveys in behalf of the American College of Surgeons, the American Board of Surgery and the A.M.A.)

Pending outcome of the present negotiations, we have been advised that the American College of Surgeons will continue its present program.

It is our hope that the program so successfully carried out by the college over the last 30 years can be expanded under a plan acceptable to all organizations concerned, and that such a program will prove even more effective in bringing about the results toward which the several organizations are striving, that of better patient care.—The Modern Hospital, November, 1950.

COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE

The recent proclamation of the President to the effect that all physicians who are under 50 years of age and who are not members of one of the reserve components of the armed forces must register with the Selective Service System prior to January 16, 1951, will undoubtedly raise questions in the minds of many former medical officers as to their present reserve status. The Council on National Emergency Medical Service has therefore obtained the following statements from the offices of the Surgeons General of the departments of the Army, Navy and Air Force.—Robert M. Hall, M.D., Secretary.

Status of Former Army Medical Officers

The key to whether a person, once commissioned, now holds a reserve commission lies in his letter of appointment. If the letter states that the appointment was made under Section 37, National Defense Act, as amended; sets forth the grade, serial number and effective date, and states that "by direction of the President you are appointed in the Officer's Reserve Corps," he holds a reserve commission and it is still effective, unless notice of termination has been received from the Adjutant General.

Some of the older letters of appointment do not mention "Section 37 . . ." or "Officers' Reserve Corps," However, they do mention that the appointment is in the Reserve, in connection with the person's name, rank and corps (e.g., John Smith, 1st Lt. Med. Res.). Holders of such letters of appointment also hold a reserve commission, and it is still effective unless officially terminated.

Appointments in the Officers' Reserve Corps are for five years, subject to renewal. During the war all reserve commissions were automatically extended for the duration of the emergency plus six months. Since no official declaration has been made ending the emergency, such commissions are still in force, with the exception of those which have been terminated through resignation by the individual and acceptance by the government or which have been terminated for cause or the convenience of the government.

During World War II many persons were commissioned directly in the Army of the United States (AUS). These commissions do not constitute appointment in the Officers' Reserve Corps. AUS commissions authorized during the period of World War II, under the provisions of Section 37, National Defense Act, as amended, are valid and will remain in force for the duration of the war and six months thereafter. All other AUS commissions were terminated by Public Law 239 of the Eightieth Congress.

If the letter of appointment or other pertinent papers have been lost and the person is still uncertain of his reserve status, he should write directly to the Adjutant General of the Army, Attention: Reserve Branch, Washington 25, D. C. The letter should contain a direct request as to whether the person holds a reserve commission and, if so, whether the commission is in force at this time. The letter should contain the writer's Army serial number.

Any statement to a person concerning his reserve status or nonreserve status which comes from any source other than the Adjutant General is not official.

Status of Former Navy Medical Officers

Medical officers of the Navy who served as reserve medical officers on active duty during World War II and have since returned to an inactive status are, in the majority of cases, still commissioned as reserve medical officers of the Navy. When these officers were released to in-

active status from active duty, it was necessary that the individual take positive action to resign his commission in order to change his status from that of reserve medical officer to a civilian. A release to inactive duty did not automatically cancel the reserve commission which the officer had been issued prior to or at the time he went on active duty.

Physicians and dentists may have resigned their commission after their release to inactive duty, but this resignation was necessary as an individual action on the part of each person, who must have submitted his resignation of commission to the Secretary of the Navy or to other proper authority. Those physicians who are still doubtful as to their present status may obtain clarification by addressing an inquiry to the Surgeon General, Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

Status of Former Air Force Officers

Those physicians who served with the Army Air Forces prior to the designation of the Air Force as a separate military department served as Army medical officers, and the above statements concerning AUS and Army Reserve commissions are applicable to them. Those with reserve commissions still hold these commissions in the Army unless they have personally applied for transfer to the Air Force Reserve and have received notification that such a transfer has been effected.—Journal of the American Medical Association, November 11, 1950.

EDITORIAL COMMENT

HOSPITAL STANDARDIZATION PROGRAM TO CONTINUE

At their meeting October 21, 1950, the Regents of the American College of Surgeons voted unanimously to continue the Hospital Standardization Program of the College.

A spokesman for the Regents stated that this action does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public.

RANDOM THOUGHTS OF THE SECRETARY

October 15th. In prolonged session with lengthy discussion only over the possibilities of extending society membership along the lines promulgated by the Democratic party, the Council disposes of many matters, and we are afforded opportunity to sit in on the closing moments of the procurement and assignment committee meeting, now entitled Advisory Committee to the National Security Resources Board, a title to afford small consolation for the drudgery.

October 20th. In a game highlighted more by an exuberance of personal combativeness rather than by display of gridiron skill, the locals win from Russellville but fears of mass hostilities fade as calmer heads take over following the game.

October 24th. By rail with President Hunt, sleep being limited, to Dallas for the A.M.A. legislative conference, joining Henry, Thomas, Watkins, Wrightsman, and Jean and Lou Hundley. This couple exuberantly celebrating today fifteen years and one day of a more than eventful married life and carrying over to the full assemblage some of the happiness that they have on the occasion. Returning, leaving the Katy train at Muskogee and on into home with slumber mostly desired and bidding the President comfort as Rip drives him to Clarksville in the early morn.

October 28th. With the Prides, the Stewarts and the Whittakers to Tulsa, the trip enlivened by varying discussions, none related to the practice of medicine, dining in Hotel Tulsa which demotes itself as a purveyor of properly served food although quality remains, and to the magnificent "Ice Cycles of 1951," entertainment superb, homeward and with Whittaker's guidance, finally discovering just where that road which continues on when Highway 64 turns leads, although we had misgivings over the lonely miles we traveled in making the discovery.

November 2nd. Visiting Hathcock, Sr., in Fayetteville this afternoon, the visit turning into a search for radioactive material in the form of a radium tube, happily located without the use of Geiger-Muller counters.

November 5th. On this fine Arkansas day motoring to Little Rock, noting active campaign effort by cattle for the stock law along Highway 10 in Perry and Pulaski counties; to the cordial reception for Dean Nichols where we greet many a Little Rock colleague; dining in the grand manner in one of the Albert Pike's newly-decorated rooms, Host Walter Davis doing the inn proud in both food and service, and homeward completely in keeping with the tempo along this lone highway, our conversational banter with Peggy at a irreducible minimum but happy with all things for a pleasant day, a good life and friends.

November 8th. By the highway bus along number ten where Perry and Pulaski county cows have not heard of the election to a public relations meeting with Rember, the perennial discussion of the $25 appearing, but the meeting highlighted by the Canadian tweed jacket which Verser, the Duke of Harrisburg, is wearing and Seigel's naive explanation for the failure of physicians to locate in small communities—the lack of a Community Chest, and homeward with Wrightsman who was in a hurry to get to sleep.



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● A detailed caduceus in brillia per finish. Set upon a green which has a red reflector back Available with the letters M.D.
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● A smooth leather physician's bag, which has compartments in each lid that folds outward. Bag is 17" long, 6½" wide and 11" high. "H" $34.00

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Wilson, J. G. — Keo

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Barnes, L. C. — Hamburg
Bryant, E. P. — Crossett
Cockerham, H. E. — Portland
Cone, A. E. — Portland
Cothern, W. R. — Crossett
Crandall, M. C. — Wilmot
Gresham, Edward G. — Crossett
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Hoyt, Jonathan — Crossett
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Gray, E. M. — Mountain Home
Pruitt, W. H. — Mountain Home
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†Buckelew, H. H. — Rogers
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Compton, Neil — Bentonville
Dean, Lee A. — Rogers
Gulledge, J. F. — Siloam Springs
Hodges, Guy — Rogers
Huskins, J. D. — Siloam Springs
Jackson, J. L. — Bentonville
Jennings, W. E. — Rogers
Love, Geo. M. — Rogers
Moore, W. A. — Rogers
Peacock, A. L. — Gentry
Pickens, J. L. — Rogers
Rollow, John A. — Bentonville
Siler, K. A. — Siloam Springs
White, Harry M. — Rogers
Williams, Rex — Siloam Springs
Wilson, C. S. — Siloam Springs
Wilson, Stewart M. — Rogers

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Breit, Wm. H. — Harrison
Fowler, Ross — Harrison
Frailey, D. M. G. — Harrison
Gladden, J. C. — Harrison
Gladden, J. G. — Harrison
Jackson, Ulys — Harrison
Kirby, H. V. — Harrison
†Morrow, J. J. — Mountain Home
McCoy, O. B. — Harrison
Owens, D. L. — Harrison
Pearce, C. G. — Miami, Fla.
Weast, L. M. — Yellville

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Dew, Hogan A. — Warren
Grene, Robert E. — Warren
Hunt, W. J. — Warren
Reasons, W. B. — Hermitage
Roark, W. N. — Hermitage

CARROLL COUNTY

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Carter, A. L. — Berryville
Donaldson, C. W. — Green Forest
John, J. F. — Eureka Springs
McCurry, D. K. — Green Forest
Poynor, Chas. — Berryville
Smith, Fred C. — Eureka Springs
Van Pelt, Ross — Eureka Springs

CHICOT COUNTY

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Barlow, B. E. — Dermott
Binns, B. Z. — Eudora
†Bottorff, M. K. — Lake Village
Burge, J. H. — Lake Village
Clark, B. C. — Lake Village
Douglas, S. W. — Eudora
Easterling, W. D. — Lake Village
Johnston, G. C. — Lake Village

† Deceased

McDonald, Robert — Eudora
McGehee, E. P., Jr. — Lake Village
Thomas, H. W. — Dermott

CLARK COUNTY

Anderson, P. R. — Arkadelphia
Barnett, J. R. — Arkadelphia
Bremer, J. P. — Point Cedar
Bryant, R. L. — Arkadelphia
Clark, Chas. G. — Arkadelphia
Doane, S. N. — Arkadelphia
Hill, Wm. T. — Gurdon
Kennedy, Jack W. — Arkadelphia
†Norton, J. M. — Arkadelphia
Pate, J. N. — Arkadelphia
Pinkerton, R. E. — Amity
Reid, Joe Winston — Arkadelphia
Ross, W. A. — Arkadelphia
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Futrell, J. B. — Rector
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Jones, F. H. — Piggott
Latimer, N. J. — Corning
Turner, W. E., Sr. — Piggott
Turner, W. E., Jr. — Piggott

CLEVELAND COUNTY

Hancock, W. G. — Rison
Scroggin, J. H. — Benton

COLUMBIA COUNTY

Baker, J. J. — Magnolia
Burt, E. G. — Magnolia
Carrington, H. K. — Magnolia
Horn, W. H. — Magnolia
Houston, Evan G. — Magnolia
Jones, T. H. — Waldo
Jordan, T. S. — Magnolia
Kitchens, H. H. — Waldo
McLeod, G. F. — Magnolia
Mullins, G. E. — Emerson
Ruff, John L. — Magnolia
Rushton, J. F. — Magnolia
Sizemore, Paul — Magnolia
Souter, A. J. — Waldo
Souter, T. E. — McNeil
Weber, Chas. L. — Magnolia
Wilson, John H. — Magnolia

CONWAY COUNTY

Etheridge, C. E. — Morrilton
Hardison, T. W. — Morrilton
Holloway, O. R. — Morrilton
Mobley, H. E. — Morrilton
Porter, James O., Jr. — Morrilton
Williams, C. R. — Morrilton

CRAIGHEAD-POINSETT COUNTY

Alcott, Geo. B. — Bald Knob
Barrett, E. R. — Jonesboro
Berry, W. E. — Jonesboro
Blanton, M. E. — Jonesboro
Burge, H. G. — Nettleton
Cohen, O. T. — Jonesboro
Cohen, Robt. S. — North Little Rock
Dickerson, D. A. — Marked Tree
Faris, John C. — Jonesboro
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Harper, Bland R. — Monette
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†Hartwig, C. D. — Lake City
Horner, E. J. — Jonesboro
Jones, J. K. — Lepanto
Kennamer, Harold E. — Marked Tree
Ledbetter, Jos. W. — Jonesboro
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McCurry, J. H. — Cash
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Modelevsky, A. C. — Jonesboro
Moreland, W. H. — Tyronza
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Shanlever, R. C. — Jonesboro
Shepherd, W. F. — Jonesboro
Smith, O. V. — Trumann
Smith, W. H. — Bono
Sternberger, Saul, Jr. — Lepanto
Stroud, E. J. — Jonesboro
Stroud, H. A. — Jonesboro
Stroud, P. T. — Jonesboro
Tullos, A. M. — Trumann
Verser, Joe — Harrisburg
Verser, W. W. — Harrisburg
Webb, J. W. — Jonesboro
Willett, R. H. — Jonesboro

CRAWFORD COUNTY

Bennett, B. L. — Van Buren
Cowan, Riley — Van Buren
Dixon, Chas. B. — Van Buren
Galloway, Q. R. — Alma
Grant, S. C. — Fort Smith
Kirkland, S. D. — Van Buren
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Koenig, Peter W. — Alma
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Savery, H. W. — Van Buren

CRITTENDEN COUNTY

Deneke, M. D. — West Memphis
Hamilton, R. B. — West Memphis
Hare, T. S. — Crawfordsville
Irby, J. T. — Earle
McVay, L. C. — Marion
Parker, A. C., Sr. — Clarkedale
Parker, A. C., Jr. — Poplar Bluff, Mo.
Ray, Robert H. — Earle
Schoettle, G. P. — West Memphis
Shook, B. S. — West Memphis

CROSS-ST. FRANCIS COUNTY

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†Bogart, C. N. — Forrest City
Chaffin, E. J. — Hughes
Cogburn, H. N. — Forrest City
Crawley, C. E. — Forrest City
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Franks, R. H. — Hughes
Garner, Onyx P. — Wynne
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Lamb, J. W. — Wynne
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DALLAS COUNTY

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Estes, E. E. — Fordyce
Taylor, J. E. M. — Sparkman

DESHA COUNTY

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Biscoe, Goree — Dumas
Hawkins, Rowland D. — U. S. Navy
Hellums, J. H. — Dumas
Kimbro, C. H. — Tillar
Leverett, Chas. G. — McGehee
Moss, Swan B. — McGehee
Rands, H. A. — Dumas
Robinson, Guy U. — Dumas
Smith, H. T. — McGehee

DREW COUNTY

Binns, Van C. — Monticello
Holder, J. B., Jr. — Monticello
Hyatt, C. Lewis — Monticello
Hyatt, Robt. F. — Monticello
Price, J. P., Jr. — Monticello
Wells, T. L. — Monticello

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Archer, C. A., Jr. — Conway
Bannister, B. F., Jr. — Conway
Dawson, R. L. — Bee Branch
Dickerson, Cecil H. — Conway
Downs, J. H. — Vilonia
Dunaway, E. L. — Conway
Fraser, N. E. — Conway
Gordy, L. F., Jr. — Conway
Harrod, George — Conway
Hassell, L. L. — Conway
Hinkle, R. A. — Conway
Ingram, E. M. — Enola
Johnston, W. W. — Martinsburg, W. Va.
Lieblong, J. S. — Greenbrier
Lieblong, Keller — Conway
Mabry, Tom — Vilonia
McCollum, I. N. — Conway
Taylor, R. L. — Conway

FRANKLIN COUNTY

Bollinger, W. H. — Charleston
Gibbons, D. L. — Ozark
Gibbons, W. H. — Ozark
Long, C. C. — Ozark
Pillstrom, E. W. — Ozark

GARLAND COUNTY

Adams, Frank M. — Hot Springs
Atkinson, R. H. — Hot Springs
Black, T. N. — Hot Springs
Bohnen, Loren O. — Hot Springs
Bollmeier, L. N. — Hot Springs

Browning, E. R. — Hot Springs
Burch, N. B. — Hot Springs
Burton, F. M. — Hot Springs
Chamberlain, W. W. — Hot Springs
Chenault, H. Clay — U. S. Army
Chesnutt, J. H. — Hot Springs
Clardy, E. K. — Hot Springs
Coffey, G. C. — Hot Springs
Connell, W. H. — Hot Springs
Daniel, R. L. — Hot Springs
Dembinski, T. H. — Hot Springs
Dodson, John, Jr. — Hot Springs
Ellsworth, E. H. — Hot Springs
Fletcher, Geo. B. — Hot Springs
Fotioo, Geo. J. — Hot Springs
Garratt, C. E. — Hot Springs
Goetze, Dorothy — Hot Springs
Gray, W. E. — Hot Springs
Hebert, Gaston A. — Hot Springs
Holmes, M. Charlotte — Hot Springs
Jackson, H. G. — Little Rock
Jackson, W. W. — Hot Springs
King, Leeman H. — Hot Springs
King, O. H. — Hot Springs
Klugh, W. G. — Hot Springs
Leatherman, J. W. — Hot Springs
Lee, D. C. — Hot Springs
Lutterloh, C. H. — Hot Springs
Martin, L. G. — Hot Springs
Moss, C. S. — Hot Springs
Parkerson, C. W. — Hot Springs
Pate, C. N. — Hot Springs
Phillips, James E. — Hot Springs
Porter, W. F. — Hot Springs
Power, A. R. — Hot Springs
Reed, L. E. — Hot Springs
Rosenzweig, J. L. — Hot Springs
Rowland, Driver — Hot Springs
Rowland, J. F. — Hot Springs
Scott, Jett O. — Hot Springs
Scully, F. J. — Hot Springs
Shaw, E. I. — Hot Springs
Short, Z. N. — Hot Springs
Smith, E. M. — Hot Springs
Smith, O. A. — Hot Springs
Smith, W. K. — Hot Sorings
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Stough, D. B. — Hot Springs
Strachan, J. B. — Hot Springs
Tarleton, F. S. — Hot Springs
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Wade, H. K., Sr. — Hot Springs
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Weil, S. D. — Hot Springs
Wenger, O. C. — Hot Springs
Wilkins, J. S. — Hot Springs
Woods, Paul H. — Hot Springs
Wright, H. K. — Hot Springs
Wright, Jack — Hot Springs

GRANT COUNTY

†Cole, Chas. F. — Prattsville
Irvin, Jack M. — Sheridan
Kelly, Miles F. — Sheridan
Kelly, O. R. — Sheridan

GREENE COUNTY

Baker, Clark M. — Paragould
Blackwood, J. D. — Jonesboro
Bridges, G. P. — Paragould
Dillman, J. A. — Paragould
Ellington, W. E. — Paragould
Garner A. Dillon — Paragould
Haley, R. J., Jr. — Paragould
Hutcherson, R. L. — Delaplaine
Lamb, W. McD. — Paragould
Maddox, A. H. — Paragould
McKelvey, Earle — Paragould
Pennington, H. A. — Paragould
Williams, J. M. — Paragould

HEMPSTEAD COUNTY

Branch, J. W. — Hope
Cannon, G. E. — Hope
Heller, H. G. — Kansas City, Mo.
Lile, L. M. — Ft. Worth, Tex.
Martindale, J. G. — Hope
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Robins, W. F. — Ozan
Sims, Walter L. — Hope
Smith, Don — Hope
Wright, George H. — Hope

HOT SPRING COUNTY

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Berry, Morgan C. — Malvern
Brown, H. L. — Malvern
Cole, John W. — Malvern
Ellis, C. R. — Malvern
Hodges, T. L. — Bismarck
Kersh, N. B. — Malvern
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McCray, R. V. — Malvern
Peters, Claude F. — Malvern

HOWARD-PIKE COUNTY

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Dildy, E. V., Jr. — Nashville
Duncan, M. D. — Murfreesboro
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Gould, W. B. — Glenwood
Harrison, A. Vale — Dierks
Holt, H. H. — Nashville
Hopkins, Ed G. — Nashville
Jones, W. J. — Glenwood
Junell, C. M. — Mineral Springs
Toland, Wm. H. — Nashville
Waldrop, J. G. — Nashville

INDEPENDENCE COUNTY

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Barnett, J. C. — Heber Springs
Bone, O. L. — Newark
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Calaway, R. L. — Batesville
Calaway, W. H. — Batesville
Churchill, C. A. — Batesville
Craig, M. S. — Batesville
Dunbar, J. C. — Salem
Evans, L. T. — Batesville
Gray, W. Paul — Batesville
Harris, C. L. — Melbourne
Hinkle, C. G. — Batesville
Hooper, Rector C. — Dallas, Texas
Jefferies, Wm. L. — Melbourne
Jeffery, Paul H. — Bethesda
Johnston, O. J. T. — Batesville
Jones, W. A. — El Paso, Tex.
Junkin, Ruth H. — Batesville
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McAdams, V. D. — Cord
Monfort, J. J. — Batesville
Robertson, S. N. — Sulphur Rock
Roe, C. E. — Viola
Taylor, C. A. — Batesville
Walker, A. T. — Mammoth Spring
Weathers, J. L. — Salem
Woods, O. S. — Salem
Wyatt, F. Q. — Batesville

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Gray, C. R. — Newport
Harris, M. H. — Newport
Harris, M. L. — Newport
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Jackson, J. F. — Newport
Kimberlin, K. K. — Tuckerman
Norris, R. O. — Tuckerman
Walker, H. O. — Newport
Williams, Thos. E. — Newport

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Bruce, W. H. — Pine Bluff
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Capel, H. T. — Pine Bluff
Carruthers, C. K. — Pine Bluff
Causey, H. A. — Pine Bluff
Clark, O. W. — Pine Bluff
Cunningham, T. J. — Pine Bluff
Cunningham, T. J., Jr. — Pine Bluff
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Fowler, Arthur — Humphrey
Fowler, Arthur, Jr. — Pine Bluff
Fowler, H. D. — Humphrey
Hames, Fred Wm. — Pine Bluff
Hart, James C., Jr. — Pine Bluff
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Hundley, Louis K. — Pine Bluff
†Jenkins, J. S. — Pine Bluff
Lowe, W. T. — Pine Bluff
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McMullen, E. C. — Pine Bluff
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Reed, Enoch F., Jr. — Pine Bluff
Reid, Chas. W. — Pine Bluff
Rhyne, James T. — Pine Bluff
Russell, A. R. — Pine Bluff
Shelton, M. A. — Altheimer
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Talbot, Geo. B. — Pine Bluff
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Hardgrave, Geo. L. — Clarksville
Hunt, Earle H. — Clarksville
Kolb, J. M. — Clarksville
Manley, R. H. — Clarksville
Scarborough, Wm. R. — Clarksville
Shrigley, Guy P., Jr. — Clarksville
Siegel, G. R. — Clarksville

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†Baker, F. E. — Stamps
Harrison, Robt. H. — Lewisville
Jones, W. E., Jr. — Seminole, Okla.
Keith, A. W. — Stamps
Lee, Willie J. — Stamps
McKnight, J. F. — Bradley

LAWRENCE COUNTY

Blaine, Mitchell — Mammoth Spring
Cruse, E. J. — Black Rock
Elders, J. B. — Walnut Ridge
Faircloth, R. S. — Walnut Ridge
Joseph, Ralph — Walnut Ridge
†Kendall, W. S. — Cave City
Kirkley, John B. — Imboden
†Land, J. C. — Walnut Ridge
Tibbels, Chas. D. — Black Rock
Townsend, C. C. — Walnut Ridge

LEE COUNTY

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Chaffin, C. W. — Moro
Dozier, Floyd — Marianna
Hays, Wm. C., Jr. — Marianna
McClendon, Mac — Marianna

LINCOLN COUNTY

Bailey, B. L. — Star City
Dale, Robt. A. — Star City
Dixon, C. W. — Gould
Gardner, B. M. — Star City
Wood, G. C. — Grady

LITTLE RIVER COUNTY

Davis, Elmer — Foreman
Peacock, Norman — Ashdown
Shelton, J. G., Jr. — Ashdown

LOGAN COUNTY

Dickey, A. B. — U. S. Army
Hederick, A. R. — Booneville
Henry, C. A. — State Sanatorium
Jewell, I. H. — Paris
McConnell, S. P. — Booneville
Riley, J. D. — State Sanatorium
Smith, Chas. McD. — Paris
Smith, James T. — Paris
Smith, John F. — Paris
Stanfield, Wayne — Booneville

LONOKE COUNTY

Beaty, S. S. — England
Brewer, John F. — Scott
Crowgey, Wm. B. — Scott
Duty, Edward R. — Carlisle
Holmes, Byron E. — Lonoke
Kelly, R. M. — Lonoke
Millwee, Fay B. — U. S. Army
Southall, S. A. — Lonoke
†Ward, O. D. — England
Washburn, C. Yulon — Cabot

MADISON COUNTY

Acree, W. E. — Huntsville
Beeby, Chas. B. — Huntsville
Youngblood, Fred — Huntsville

MILLER COUNTY

Baldridge, Doris — Texarkana
Baldridge, Max — Texarkana
Baskett, Roy F. — Texarkana
Burnett, J. W. — Texarkana
Carney, H. M. — Texarkana
Collom, S. Allan — Texarkana
Daniel, N. B. — Texarkana
Ellison, E. T. — Texarkana
Frank, C. H. — Texarkana
Good, L. P. — Texarkana
Harrell, W. B., Jr. — Texarkana
Harrison, R. K. — Texarkana
Jones, John W. — Texarkana
Jones, Wm. E. — Texarkana
Kemp, K. H. — Texarkana
King, Jack — Linden, Tex.
Kirkpatrick, R. R. — Texarkana
Kittrell, J. B. — Texarkana
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Kosminsky, L. J. — Texarkana
Lanier, L. H. — Texarkana
Laws, J. K. — Texarkana
Little, A. A. — Texarkana
Meredith, Wm. R. — Joiner
Middleton, B. C. — Texarkana
Murry, H. E. — Texarkana
Parson, G. W. — Texarkana
Pickett, R. W. — Texarkana
Roberts, A. W. — Texarkana
Smith, W. D. — Texarkana
Tate, J. B. — Texarkana
Teasley, Gerald H. — Texarkana
Wilhelm, Frieda — Texarkana
Williams, J. F. — Texarkana
Yarbrough, Chas. P. — Texarkana

MISSISSIPPI COUNTY

Atkinson, G. S. — Blytheville

Beasley, J. E. ..... Blytheville
Blodgett, D. H. ..... Luxora
Brownson, J. F. ..... Blytheville
Danner, J. J. ..... Armorel
Elliott, John ..... Blytheville
Ellis, N. B. ..... Wilson
Fairley, Eldon ..... Wilson
Fairley, Julian ..... Keiser
Harwell, C. M. ..... Osceola
Hollingsworth, G. F. ..... Dyess
Hubener, L. L. ..... Blytheville
Hubener, Louis F. ..... Blytheville
Husband, F. L. ..... Blytheville
Johnson, I. R. ..... Blytheville
Johnson, R. L. ..... Blytheville
Massey, L. D. ..... Osceola
Polk, J. T. ..... Keiser
Rainwater, W. T. ..... Blytheville
Ratton, Robt. W. ..... Manila
Robinson, Finley ..... Blytheville
Rodman, T. N. ..... Leachville
Saliba, J. A. ..... Blytheville
Scott, B. F. ..... Blytheville
Sheddan, W. J. ..... Osceola
Sims, H. C. ..... Blytheville
Skaller, M. L. ..... Blytheville
Utley, F. E., Jr. ..... Blytheville
Walls, J. M. ..... Blytheville
Webb, Floyd ..... Blytheville
Webb, J. J. ..... Blytheville

MONROE COUNTY

Dalton, M. L. ..... Brinkley
McKnight, C. H. ..... Brinkley
McKnight, E. D. ..... Brinkley
Mohler, D. A. ..... Brinkley
Pearce, J. L. ..... Morristown, Tenn.
Pupsta, B. F. ..... Clarendon
Stone, H. E., Jr. ..... Holly Grove
Walker, W. L. ..... Brinkley
Williams, J. P., Jr. ..... Brinkley

NEVADA COUNTY

Arnold, C. P. ..... Prescott
Buchanan, A. S. ..... Prescott
Cox, J. E. ..... Rosston
Hairston, G. G. ..... Prescott
Harrell, L. J. ..... Prescott
Hesterly, J. B. ..... Prescott
Hirst, O. G. ..... Prescott
Pool, W. B. H. ..... Rosston
Rouse, B. H. ..... Prescott

OUACHITA COUNTY

Byrd, E. J. ..... Camden
Dalton, Perry ..... Camden
Dedman, J. L., Jr. ..... Camden
Drewery, L. E. ..... Camden
Guthrie, James ..... Camden
Hearnsberger, Henry ..... Stephens
Jameson, J. B. ..... Camden
McAlister, J. P. ..... Camden
McGill, S. D. ..... Camden
Meek, Tom J. ..... Camden
Miller, John H. ..... Camden
Partee, N. G. ..... Camden
Rhine, T. E. ..... Thornton
†Rinehart, J. S. ..... Camden
Robins, R. B. ..... Camden
Robins, R. R. ..... Camden
Rushing, J. L. ..... Chidester
Stevenson, B. M. ..... Camden
Thompson, John P. ..... Bearden

PHILLIPS COUNTY

Berger, Alfred H. ..... Helena
Butterick, O. D. ..... Elaine
Capes, B. ..... West Helena
Chrestman, R. L., Jr. ..... Helena
Connolly, W. B. ..... Helena
Cox, A. E. ..... Helena
Ellis, W. A., Jr. ..... Helena
Fink, Montague ..... Helena
Gibbons, G. E. ..... Marvell
†Hosey, N. R. ..... Marvell
Kultgen, Edward ..... Elaine
McCarty, C. P. ..... Helena
Nicholls, J. W. ..... Helena
Norton, E. F. ..... Marvell
Oldham, H. B. ..... Marvell
Storm, Geo. R. ..... West Helena
Terry, John B. ..... West Memphis

POLK COUNTY

Campbell, C. A. ..... Mena
Lee, F. A. ..... Vandervoort
Norwood, Frank A. ..... Mena
Redman, Pierre ..... Mena
Rogers, Henry N. ..... Mena
Stewart, G. T. ..... Mena
Williams, L. K. ..... Mena

POPE-YELL COUNTY

Blackford, Florence ..... Russellville
Blackford, Ralph E. ..... Russellville
Blackford, Roger W. ..... Russellville
Cale, W. M. ..... Atkins
Gardner, Ellis ..... Russellville
Gardner, L. ..... Russellville
Gillium, A. D. ..... Belleville
Grace, Kent ..... Arlington, Va.
Henry, J. A. ..... Russellville
Henry, Wm. A. ..... Russellville
Hood, Robert ..... Russellville
Hunt, E. C. ..... Ola
King, Ernest ..... Russellville
Lane, Walter H., Jr. ..... Dover
Lichtenberg, Robt. P. ..... Russellville
Linton, A. C. ..... Hector
Millard, Roy I. ..... Russellville
Miller, A. Watson ..... Russellville
Mobley, Max J. ..... Russellville
Montgomery, H. L. ..... Gravelly
Smith, R. L. ..... Russellville
Stanford, J. M. ..... Russellville
Tate, A. B. ..... Russellville
Teeter, Brooks R. ..... Russellville
Underwood, E. O. ..... Waveland
Webb, Lewis A. ..... Dardanelle
Young, W. O., Jr. ..... Russellville

PRAIRIE COUNTY

Crockett, W. H. ..... Benton
Gilliam, J. C. ..... Des Arc
Hill, Roy F., Jr. ..... Brookville, Miss.
Matthews, Travis ..... Hazen
Parkes, W. M. ..... DeValls Bluff

PULASKI COUNTY

Adametz, J. H. ..... Little Rock
Aday, J. Leo ..... Little Rock
Agar, Drew F. ..... U. S. Navy
Alford, Dale ..... Little Rock
Allen, H. R. ..... Little Rock
Almaden, P. J. ..... Little Rock
Arkebauer, C. A. ..... Van Buren
Armstrong, H. M. ..... Little Rock
Atkinson, Shelby ..... North Little Rock
Ault, Chas. C. ..... Little Rock
Autry, D. H. ..... Little Rock
Autry, P. G. ..... Little Rock
Banks, Jeff ..... Little Rock
Barker, E. M. ..... Jacksonville
Barrier, L. F. ..... Little Rock
Beard, Owen W. ..... Little Rock
Beck, R. W. ..... Little Rock
Bennett, B. A. ..... Little Rock
Bizzell, Ross ..... Little Rock
Black, M. W. ..... Little Rock
Blakely, R. M. ..... Little Rock
Briggs, B. P. ..... Little Rock
Brizzolara, A. J. ..... Little Rock
Brooks, C. M. ..... Little Rock
Brooks, W. A. ..... Little Rock
Brown, Martha M. ..... Little Rock
Brown, T. Duel ..... Little Rock
Brown, Willis E. ..... Little Rock
Bryant, R. H. ..... Little Rock
Buchman, J. A. ..... Little Rock
Burgess, T. E. ..... Little Rock
Burns, W. M. ..... North Little Rock
Byrd, L. M., Jr. ..... Little Rock
Calcote, R. A. ..... Little Rock
Calcote, R. J. ..... Little Rock
Case, I. C., Jr. ..... Little Rock
Cavener, J. L. ..... Little Rock
Cazort, Allan G. ..... Little Rock
Calhoun, J. D. ..... Little Rock
Caldwell, Robt. ..... Little Rock
Carnahan, R. G. ..... Little Rock
Carruthers, F. W. ..... Little Rock
Chappell, Ewin S. ..... North Little Rock
Cheairs, D. B. ..... Little Rock
Chesnutt, C. R. ..... Little Rock
Chesnutt, C. R., Jr. ..... Little Rock
Choate, H. L. ..... Little Rock
Christeson, W. W. ..... Pierre, So. Dakota
Church, B. L. ..... North Little Rock
Clark, A. C. ..... Little Rock
Clark, Wm. A. ..... Little Rock
Cohen, Louis A. ..... Little Rock
Compton, J. N. ..... Little Rock
Coon, A. B. ..... Little Rock
Cook, R. C. ..... Little Rock
Cooper, Wm. G. ..... Little Rock
Cope, E. P. ..... Little Rock
Corn, F. A. ..... Little Rock
Cosgrove, K. W. ..... Little Rock
Craig, M. S., Jr. ..... Little Rock
Crawford, J. B. ..... Little Rock
Crawley, Eugene H. ..... Little Rock
Cull, S. T. W. ..... Little Rock
Cullen, P. T. ..... Little Rock
Cummins, Bryce ..... Little Rock
Curtis, A. C. ..... Little Rock
Cutting, Herwald ..... Little Rock
Darby, Wm. J. ..... Nashville, Tenn.
Darnall, R. F. ..... Alexander
Dean, G. O. ..... Little Rock
Dibrell, J. R. ..... Little Rock
Dildy, Hal ..... Little Rock
Dishongh, H. A. ..... Little Rock
Dodge, Eva F. ..... Little Rock
Donahue, H. H. ..... Little Rock
Donaldson, J. K. ..... Little Rock
Earle, A. M. ..... Little Rock
Easley, E. J. ..... Little Rock
Eubanks, R. M. ..... Little Rock
Faust, W. H. ..... North Little Rock
Fein, Norman N. ..... Little Rock
Fletcher, Elizabeth D. ..... Little Rock
Freedman, Theodore ..... Little Rock
Fulmer, D. W. ..... Little Rock
Fulmer, Herman R. ..... Little Rock
Fulmer, P. M. ..... Little Rock
Fulmer, S. C. ..... Little Rock
Fulton, Wm. L. ..... Little Rock
Gann, Dewell, Jr. ..... Benton
Gates, Stanley M. ..... Little Rock
Gay, E. C. ..... Little Rock
Gordon, Vida ..... Little Rock
Goss, Jos. J. ..... North Little Rock
Grant, Walter J. ..... North Little Rock
Gray, Edwin F. ..... Little Rock
Gray, H. F. ..... Little Rock
Gray, Oscar, Jr. ..... Jacksonville
Grayson, W. B. ..... Little Rock
Greutter, J. E., Jr. ..... Little Rock
Growdon, J. H. ..... Little Rock
Hall, A. D. ..... Little Rock
Hamilton, W. M. ..... Little Rock
Hanchey, C. C. ..... North Little Rock
Harderman, D. R. ..... Little Rock
Hardin, Joe H. ..... Little Rock
Harris, F. W. ..... Little Rock
Harris, Robt P. ..... Knoxville, Tenn.
Hayes, J. D. ..... Little Rock
Hayes, J. H. ..... Little Rock
Headstream, J. W. ..... Little Rock
Henry, C. R. ..... Little Rock
Henry, J. F., Jr. ..... Little Rock
Henry, R. L., Jr. ..... Little Rock
Herron, John T. ..... Little Rock
Higgins, H. A. ..... Little Rock
Hill, Harlan H. ..... Little Rock
Hollenberg, H. G. ..... Little Rock
Hollis, N. T. ..... Little Rock
Holmes, G. M. ..... Little Rock
Holmes, H. C. ..... Little Rock
Holt, L. G. ..... Little Rock
Hoover, P. W. ..... Little Rock
Hughes, A. A. ..... Little Rock
Hundley, John M. ..... Little Rock
Hyatt, D. T. ..... Little Rock
Irons, H. S., Jr. ..... Little Rock
Jackson, Geo. W. ..... Little Rock
Jernigan, James P. ..... U. S. Army
Johnson, Glenn H. ..... Little Rock
Jones, Erner ..... Little Rock
Jones, H. Fay H. ..... Little Rock
Jones, J. E. ..... Little Rock
Jones, Kenneth G. ..... Little Rock
Jones, Robt. D. ..... Little Rock
Judd, O. K. ..... Little Rock
Junkin, S. P. ..... Little Rock
Kahn, Alfred, Jr. ..... Little Rock
Kerekes, Ernest S. ..... Little Rock
Keeling, Jack H. ..... Little Rock
Kilbury, M. J. ..... Little Rock
Kilbury, M. J., Jr. ..... Columbia, Mo.
Kirby, J. M. ..... Little Rock
Kirkham, S. H. ..... Little Rock
Kolb, A. C. ..... Little Rock
Kolb, Agnes C. ..... Little Rock
Kolb, B. T. ..... Little Rock
Kolb, W. Payton ..... Little Rock
Kory, R. C. ..... Little Rock
Kozberg, Oscar ..... Little Rock
Kumpuris, F. G. ..... Little Rock
Laman, J. E. ..... North Little Rock
Lamb, W. A. ..... Little Rock
Langston, W. C. ..... Little Rock
Law, R. A. ..... Little Rock
Lawson, Mason G. ..... Little Rock
Levy, J. S. ..... Little Rock
Lewis, G. V. ..... Little Rock
Longstreth, Alvin E. ..... Little Rock
Lyons, V. E. ..... North Little Rock
Mahoney, Paul L. ..... Little Rock
May, J. T. ..... North Little Rock
McCaskill, M. E. ..... Little Rock
McCaskill, M. R. ..... Little Rock
McClain, M. D. ..... Little Rock
McLochlin, R. E. ..... Little Rock
McMillin, Lamar ..... Little Rock
McRae, W. M. ..... Little Rock
Means, Ben D. ..... Little Rock
Melson, O. C. ..... Little Rock
Meschan, Isadore ..... Little Rock
Miles, H. C. ..... Little Rock
Miller, Harold N. ..... Little Rock
Moore, L. P., Jr. ..... Little Rock
Morgan, Verne E. ..... Little Rock
Morris, W. E. ..... Little Rock
Murphey, Pat ..... Little Rock
Nettleship, Anderson ..... Little Rock
Newbill, James ..... Little Rock
Newman, W. V. ..... Little Rock
Nisbett, James M. ..... Little Rock

Nixon, Ewing ..... Little Rock
Norton, J. A. ..... Little Rock
Nowlin, W. A. ..... Roland
Oates, Chas. E. ..... North Little Rock
Oates, Gordon P. ..... Little Rock
O'Neal, Walter H. ..... Little Rock
Parsons, J. E., Jr. ..... Little Rock
Parsons, V. E., Jr. ..... Little Rock
Phillips, Bert L. ..... Little Rock
Phillips, Sam ..... Little Rock
Phipps, W. E., Jr. ..... North Little Rock
†Poe, John S. ..... Little Rock
Pool, Chalmers ..... Little Rock
Porter, Wm. I. ..... Little Rock
Prickett, M. D. ..... Little Rock
Pringos, Andrew A. ..... Little Rock
Raney, T. J. ..... Little Rock
Ratcliff, Chas. E. ..... Wadsworth, Kans.
Reagan, G. W. ..... Little Rock
Reagan, G. W., Jr. ..... Little Rock
Reagan, L. D. ..... Little Rock
Reaves, B. J. ..... Little Rock
Reed, C. C., Jr. ..... Little Rock
Reed, E. C., Jr. ..... Little Rock
Reilly, Wm. A. ..... Little Rock
Rhinehart, B. A. ..... Little Rock
Rhinehart, D. A. ..... Little Rock
Rhinehart, Wm. J. ..... Little Rock
†Richardson, W. R. ..... Little Rock
Richmond, Samuel ..... Little Rock
Riegler, N. W., Sr. ..... Little Rock
Riegler, N. W., Jr. ..... U. S. Army
Riley, Wm. K. ..... Pine Bluff
Ritchey, Lloyd F. ..... Dallas, Texas
Ritchie, E. J. ..... North Little Rock
Roberts, J. N. ..... Little Rock
Rodgers, Clyde D. ..... Little Rock
Rosenbaum, Carl A. ..... Little Rock
Ross, Robt. W. ..... Little Rock
Ross, T. T. ..... Little Rock
Rothert, Frances C. ..... Little Rock
Rowen, R. E. ..... Little Rock
Rushia, Edwin L. ..... Little Rock
Sadler, W. L. ..... Little Rock
Samuel, John M. ..... Little Rock
Sanderlin, J. H. ..... Little Rock
Sanford, Sloan M. ..... Searcy
Savin, J. E. ..... Little Rock
Saxon, R. L. ..... Little Rock
Scarborough, J. I. ..... Little Rock
Scarlett, W. P. ..... Little Rock
Schwander, Howard ..... Little Rock
Schwarz, W. J. ..... Little Rock
Sessoms, W. D. ..... North Little Rock
Shipp, Harvey D. ..... Little Rock
Shuffield, H. Elvin ..... Little Rock
Shuffield, J. F. ..... Little Rock
Shuffield, J. W., Jr. ..... New Orleans, La.
Shukers, C. F. ..... Little Rock
Simpson, N. Henry, Jr. ..... Little Rock
Smith, H. H. ..... North Little Rock
Smith, James L. ..... Little Rock
Smith, John McC. ..... Little Rock
Smith, John W. ..... Little Rock
Smith, R. T. ..... Little Rock
Smith, W. Meyers ..... U. S. Army
Snodgrass, Wm. A., Jr. ..... Little Rock
Sparks, A. R. ..... Little Rock
Spitzberg, Irving J. ..... Little Rock
Stathakis, John ..... North Little Rock
Steele, Volney W. ..... U. S. Navy
Steinkamp, G. R. ..... U. S. A. F.
Stover, A. R. ..... Kingman, Ariz.
Strauss, A. W., Sr. ..... Little Rock
Strauss, A. W., Jr. ..... Little Rock
Summers, J. A. ..... Little Rock
Switzer, D. M. ..... North Little Rock
Talbot, A. G. ..... DeWitt
Thomas, P. E. ..... Little Rock
Thomas, Peter O. ..... Little Rock
Thompson, E. I. ..... Little Rock
Thompson, G. D. ..... Little Rock
Thompson, R. F. ..... Little Rock
Thompson, S. B. ..... Little Rock
Tommey, Chas. E. ..... Little Rock
Toombs, V. L. ..... Little Rock
Turnbow, R. L. ..... Little Rock
Wallace, Deane D. ..... Little Rock
Wallis, Charles ..... Little Rock
Warden, J. R. ..... Little Rock
Washburn, A. M. ..... Little Rock
Watkins, Chas. J. ..... Little Rock
Watkins, John G., Sr. ..... Little Rock
Watkins, John G., Jr. ..... Little Rock
Wassell, J. R. ..... U. S. Navy
Watson, C. F. ..... Little Rock
Watson, C. Robt. ..... Little Rock
Wayman, A. K. ..... Little Rock
Wayne, J. R. ..... Little Rock
Webb, V. T. ..... Little Rock
Weese, W. H. ..... Little Rock
Wells, B. B. ..... Little Rock
Weny, N. F. ..... Little Rock
Wickard, C. P. ..... Little Rock
Wilkes, Elbert H. ..... Little Rock
Zell, Lawrence M. ..... Little Rock

RANDOLPH COUNTY

Baltz, M. A. ..... Pocahontas
Brown, J. W. ..... Pocahontas
DeClerk, Thomas B. ..... Pocahontas
Hamil, W. E. ..... Pocahontas
Loftis, J. R., Jr. ..... Longview, Tex.
Loftis, W. O. ..... Alexandria, La.
Ryburn, J. W. ..... Pocahontas
Scott, Wm. W. ..... Pocahontas
Smith, N. K. ..... Pocahontas
Smith, R. O. ..... Biggers

SALINE COUNTY

Ashby, John W. ..... Benton
Bell, Wm. K. ..... Benton
Blakely, M. M. ..... Benton
Buffington, T. E. ..... Benton
Jones, C. W., Sr. ..... Benton
Jones, C. W., Jr. ..... Benton
Walton, Chas. R. ..... Montgomery, Ala.

SEARCY COUNTY

Cotton, J. O. ..... Leslie
Daniel, S. G. ..... Marshall
Evans, P. L. ..... Marshall
Hall, H. J. ..... Clinton
Moore, Raymond T. ..... Seguin, Tex.
Moore, W. T. ..... Marshall
Sims, Dorsey T. ..... Auburn, Ala.

SEBASTIAN COUNTY

Adams, W. F. ..... Fort Smith
Amis, J. W. ..... Fort Smith
Benefield, C. E. ..... Fort Smith
Billingsley, C. B. ..... Fort Smith
Blair, A. A. ..... Fort Smith
Booksher, W. R. ..... Fort Smith
Chamberlain, C. T. ..... Fort Smith
Clarke, Albert S. J. ..... San Augustine, Tex.
Coffman, J. S. ..... Lavaca
Crigler, R. E. ..... Fort Smith
Dorsey, H. C. ..... Fort Smith
Eberle, W. G. ..... Fort Smith
Faier, S. Z. ..... Fort Smith
Foltz, T. P. ..... Fort Smith
Foster, M. E. ..... Fort Smith
Goldstein, D. W. ..... Fort Smith
Hall, C. W. ..... Greenwood
Hawkins, S. W. ..... Fort Smith
Henry, L. M. ..... Fort Smith
Henry, Louise M. ..... Fort Smith
Hoge, A. F. ..... Fort Smith
Hoge, M. B. ..... Fort Smith
Johnson, Hugh ..... Fort Smith
Johnson, J. E. ..... Fort Smith
Jones, E. B. ..... Hartford
Jones, I. F. ..... Fort Smith
Kennedy, Virgil ..... Fort Smith
Knight, W. E. ..... Fort Smith
Koenig, A. S. ..... Fort Smith
Kramer, Ralph G. ..... Fort Smith
Krock, F. H. ..... Fort Smith
Little, J. E. ..... Fort Smith
Martin, Art B. ..... Fort Smith
Mendelsohn, E. A. ..... Fort Smith
Moberley, Paul B. ..... Fort Smith
Moulton, E. C. ..... Fort Smith
Moulton, E. C., Jr. ..... Fort Smith
Moulton, H. ..... Fort Smith
Olson, John D. ..... Fort Smith
Pride, Ben H. ..... Fort Smith
Redman, J. W. ..... Fort Smith
Rose, W. F. ..... Fort Smith
Schirmer, Roy E. ..... Fort Smith
Scott, M. H. ..... Fort Smith
Shearer, F. E. ..... Fort Smith
Shippey, W. L. ..... Fort Smith
Stevenson, J. E. ..... Fort Smith
Stewart, J. B. ..... Fort Smith
Southard, J. S. ..... Fort Smith
Thompson, H. B. ..... Fort Smith
Thompson, J. K. ..... Fort Smith
Thompson, Robt. J. ..... Fort Smith
Waddell, Pearl B. ..... Fort Smith
Whittaker, L. A., Jr. ..... Fort Smith
Wilson, C. L. ..... Fort Smith
Woods, G. G. ..... Huntington
Woods, Wm. M. ..... Huntington
Wright, H. B. ..... Waldron

SEVIER COUNTY

Archer, C. A. ..... DeQueen
Callahan, Leroy ..... DeQueen
Dickinson, R. C. ..... Horatio
Dickinson, Richard B. ..... DeQueen
Dickinson, Rodger C. ..... DeQueen
Hendricks, J. S. ..... DeQueen
Jones, Chas. N. ..... DeQueen
Kimball, G. L. ..... DeQueen
Kitchens, C. E. ..... DeQueen
Norwood, M. L. ..... Lockesburg

UNION COUNTY

Burton, Geo. C. ..... El Dorado
Cathey, A. D. ..... El Dorado
Clark, Frank ..... El Dorado
Clowney, A. R. ..... El Dorado
Cooper, James O. ..... El Dorado
Cullins, J. G. ..... Leavenworth, Kans.
Fincher, L. G. ..... El Dorado
Fitch, L. E. ..... El Dorado
Handley, W. H., Jr. ..... El Dorado
Harper, J. W. ..... El Dorado
Henley, Paul G. ..... Smackover
Irby, F. L. ..... El Dorado
Kennedy, C. E. ..... Smackover
Kitchens, D. K. ..... New York, N. Y.
Landers, G. H. ..... El Dorado
Levine, David ..... El Dorado
Mayfield, H. F. ..... Huttig
Mayfield, H. J. ..... El Dorado
McCall, Daniel ..... Lawson
McFarland, L. H. ..... St. Louis, Mo.
McKinney, J. S. ..... El Dorado
Mitchell, J. G. ..... El Dorado
Moore, B. L. ..... El Dorado
Munn, E. J. ..... El Dorado
Murphy, G. D., Sr. ..... El Dorado
Murphy, G. D., Jr. ..... El Dorado
Murphy, H. A. ..... El Dorado
Muse, P. H. ..... Junction City
Newton, W. L. ..... Smackover
Pinson, J. H., Jr. ..... El Dorado
Rainwater, W. S. ..... Little Rock
Riley, W. S. ..... El Dorado
Sheppard, J. K. ..... El Dorado
Sheppard, J. M. ..... El Dorado
Slaughter, J. W. ..... El Dorado
Thibault, Frank ..... El Dorado
Trinca, P. J. ..... Fulton, Ky.
Wharton, J. B., Sr. ..... El Dorado
Wharton, J. B., Jr. ..... El Dorado
White, D. E. ..... El Dorado
White, Wendell J. ..... Hampton

WASHINGTON COUNTY

Applegate, C. S., Jr. ..... Springdale
Baggett, Jeff ..... Prairie Grove
Brizzolara, Chas. M. ..... Little Rock
Brogdon, Preston ..... Springdale
Brown, Spencer H. ..... Fayetteville
Butler, Geo. H. ..... Fayetteville
Butt, W. J. ..... Fayetteville
DeLaney, Jos. P. ..... Little Rock
Dorman, J. W. ..... Springdale
Ellis, E. F. ..... Fayetteville
Fowler, W. A. ..... Fayetteville
Gilbert, A. A. ..... Fayetteville
Harrison, A. J. ..... Springdale
Hathcock, Alfred ..... Fayetteville
Hathcock, Preston ..... Fayetteville
Hathcock, P. L. ..... Fayetteville
Hoge, S. F. ..... Leavenworth, Kans.
Huntington, R. H. ..... Fayetteville
Kaylor, Coy C. ..... Fayetteville
Leming, H. E. ..... Fayetteville
Lesh, Ruth Ellis ..... Fayetteville
Lesh, V. O. ..... Fayetteville
Mashburn, James D. ..... U. S. Army
McAllister, Max F. ..... Fayetteville
Miller, R. W. ..... Fayetteville
Mock, W. H. ..... Prairie Grove
Ogden, Fred W. ..... Fayetteville
Paddock, C. S. ..... Joplin, Mo.
Richardson, Fount ..... Fayetteville
Riggall, Cecil ..... Prairie Grove
Sisco, Friedman ..... Springdale
Smallwood, R. E. ..... Brookline, Mass.
Stocker, Wm. J. ..... Fayetteville
Weddington, R. E. ..... Fayetteville

WHITE COUNTY

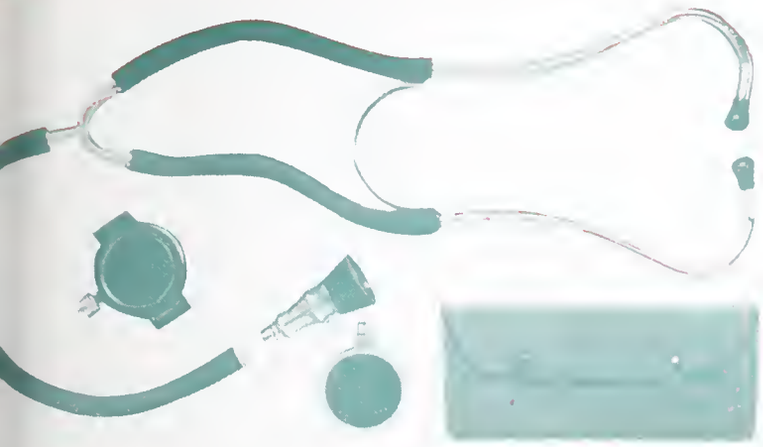
Abington, E. H. ..... Beebe
Adair, T. L. ..... Bald Knob
Allbright, S. J. ..... Searcy
Brown, Robert ..... Searcy
Dodd, Wm. Carroll ..... Bald Knob
Dunklin, A. J. ..... Searcy
Edwards, Hugh R. ..... Searcy
Felts, W. R., Sr. ..... Judsonia
Felts, W. R., Jr. ..... Washington, D. C.
Hawkins, M. C., Jr. ..... Searcy
Hudgins, A. H. ..... Searcy
Hudgins, P. T. ..... Searcy
Kinley, James D. ..... Beebe
Peeler, C. M. ..... Pangburn
Rodgers, P. R. ..... Searcy
Sloan, D. W. ..... Beebe
Sloan, J. R. ..... Garner
Spain, A. L. ..... Letona

WOODRUFF COUNTY

Brewer, E. F. ..... Augusta
Dungan, C. E. ..... Augusta
Evans, R. H. ..... Chatfield
Maguire, F. C., Sr. ..... Augusta
Maguire, F. C., Jr. ..... Augusta
Morris, J. W. ..... McCrory
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ed--Merry Christmas and Happy New Year

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Office of the Executive Secretary—311 Professional Building, Fort Smith, Arkansas.

Meeting Place—Hotel Marion, Little Rock, Arkansas, April 23-25, 1951.

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W. R. Brooksher, Fort Smith (1953)
Carl A. Rosenbaum, Little Rock (1953)
Mrs. R. C. Dickinson, Horatio (1952)



WALLACE R. RICHARDSON, age 57, Little Rock, died November 15th after an illness of six weeks. Born in Charleston, South Carolina, he had lived in Little Rock since early childhood. He attended Henderson-Brown College and Southwestern University prior to graduation from Vanderbilt University School of Medicine in 1921. His internship was served at Saint Vincent's Infirmary. He was a member of the First Methodist church, the Masonic bodies, the Shrine and of the Riverdale Country club. Surviving relatives are his wife and two sons.

HOLLIS H. BUCKALEW, Rogers, age 42, died suddenly of heart disease November 6th. Born in Haskell, Arkansas, February 26, 1908, he graduated from the University of Arkansas School of Medicine in 1939. Previously he had served as principal of the Rogers high school and had represented Benton county in the state legislature. He served in the army medical corps during World War II. He was a member of the Presbyterian church, the Rotary club, the Masonic bodies, Phi Beta Pi medical fraternity, a fellow of the American Medical Association and a member and past-president of the Benton County Medical Society and first chief-of-staff of the new Rogers hospital. Surviving relatives are his wife, to whom he was married in 1932, and a son.



TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE NUMBER of cases of unsuspected tuberculosis in the general population would be greatly reduced if physicians would require chest X-rays as a part of the routine examination of all private patients. Now as always, the physicians in private practice is a key figure in the control of tuberculosis.

CASE FINDING AMONG PRIVATE PATIENTS

It is recognized that there are many reasons for the rapid decline in the incidence of tuberculosis during the past 50 years. It is impossible to evaluate accurately, or even approximately, the relative influence of complex socioeconomic conditions and of control measures in bringing about this favorable result.

In 1937, Wade H. Frost concluded that the point had been reached in the United States where there is a gradual downward trend in the incidence of tuberculosis, and that, barring major upsets in civilization, the eventual eradication of the disease can be expected. The continued decline in the annual number of deaths from tuberculosis during the past 12 years, in spite of the adverse conditions caused by a great war, is ground for confidence in the accuracy of Frost's conclusion.

Even though control measures are only one factor in the eradication of tuberculosis, they may very well be the decisive factor. Anything which will reduce the size of the reservoir of the tubercle bacillus in human beings will lessen the number of new cases of tuberculosis. Every case of the disease, actually or potentially infectious, which is discovered and brought under control is a step in reducing the size of this reservoir. In the aggregate, control measures may represent the weight which will tip the balance in favor of the human race. It is this consideration which gives importance to any method which discloses a considerable number of cases of tuberculosis, and especially of those which are symptomless.

Although statements to the contrary have been made recently, nothing is more completely proved than the fact that approximately one-half of all cases of significant tuberculosis have no symptoms, or symptoms so slight as to escape notice. According to the National Tuberculosis Association estimates, there are a quarter of a million unknown cases of tuberculosis in the United States—at least as many as there are known cases—and recent experience indicates that the unknown cases far outnumber the known. In the 1948 mass survey in Washington, D. C., 4,098 out of 4,665 cases of tuberculosis discovered were previously unknown to the health department. Similar findings have been reported in all other large surveys.

From its small beginnings during the decade 1930-40, the mass survey method for tuberculosis detection has advanced in the United States to the point where at present about 14 million people annually undergo chest X-ray examinations. This is a significant achievement, and although it can be extended until the equipment already existing is fully utilized, it still does not represent a case-finding rate sufficiently high to insure control of the disease in any reasonable time. It is important that the mass survey programs be enlarged, but, in the meantime, every method which promises disclosure of a considerable number of cases of tuberculosis should be utilized.

Sixty to eighty million Americans, for one reason or another, annually consult a doctor, and it is known that the tuberculosis rate among them is much higher than among the general population. For this reason it is highly desirable that private physicians, including general practitioners, internists, and specialists, obtain a survey film of every patient who consults them unless the results of a recent chest X-ray survey are available.

It has been the practice of some radiologists for many years to make a single film of the chest in cases referred for other examinations, especially in cases referred for gastrointestinal study. This has disclosed many unsuspected chest conditions including tuberculosis. Now that photofluorography has greatly reduced the cost of such a survey film it should become routine practice among radiolo-

gists; its quite nominal cost can be absorbed in the major examination.

This reservoir of cases, however, is small compared with the vast number who consult general practitioners and internists. Methods can undoubtedly be devised whereby all such patients, at least those who are 15 years of age or older, can have a survey film made without cost to the patient—even a small charge would probably prevent wide use of the method. It is not necessary that any one method be adopted to accomplish the desired end. In some communities, the local or state health department could, perhaps, defray the cost as part of the general tuberculosis prevention program, especially in view of the fact that case finding in the smaller group would be relatively much more productive than in the usual mass survey. In other communities, it could be done by the tuberculosis association. In still others, general hospitals which have adopted a hospital admission X-ray survey program could enlarge the program to include survey films for the private patients of members of the hospital staff. Furthermore, it could very well become general practice among radiologists to make available such service to the general profession.

The details of such a program may seem numerous and difficult at first thought, but they can be worked out. The first essential for its success is the interest of the private physicians of each community. They are in the best position to promote it and to carry it out.

Today, because of procedures which have become routine, the private physician's office is a bulwark against such diseases as smallpox and diphtheria. In like manner, it can become one of the most effective agencies for tuberculosis control. By promoting such a public health measure, the general practitioners of the nation would be acting in line with a great tradition of the profession as a force for prevention as well as cure of disease.

Case Finding Among Private Patients, A. C. Christie, M.D., Pub. Health Rep., June 2, 1950.



PERSONALS AND NEWS ITEMS

The following have been elected surgeons of their respective American Legion posts: Henry Kirby, Harrison; L. D. Massey, Osceola; I. J. Spitzberg, Little Rock, and C. P. Arnold, Prescott.

A group from the Senior Class of the University of Arkansas School of Medicine were guests of Eli Lilly and Company at Indianapolis September 20, 21 and 22.

"Prophylaxis in Allergic Disease and Management of the Eczematoid Dermatoses of Infancy and Childhood," by Vida H. Gordon, Little Rock, appeared in The Mississippi Doctor for September, 1950.

J. T. Matthews has been elected surgeon of the Heber Springs Post, American Legion.

A. S. Koenig, Fort Smith, has been appointed councilor for Arkansas in the American Society of Clinical Pathologists.

Dr. and Mrs. D. W. Goldstein, Fort Smith, spent an October vacation at Edgewater Gulf, Mississippi.

J. J. Monfort, Batesville, has been elected Chairman, Arkansas Division, American Cancer Society.

A. S. Koenig, Fort Smith, has passed his examinations as a diplomate of the American Board of Pathology.

The following have been elected surgeons of their respective American Legion posts: A. R. Hederick, Booneville; F. S. Dozier, Marianna; J. B. Futrell, Rector; Thos. Wilson, Wynne; A. J. Forestiers, Harrisburg, and W. T. Chamption, Stuttgart.

The following were registered at the Saint Louis session of the Southern Medical Association: Hoyt R. Allen, Little Rock; Phillip J. Almaden, Little Rock; B. F. Barlow, Dermott; R. F. Baskett, Texarkana; M. E. Blanton, Jonesboro; J. P. Bremer, Point Cedar; W. E. Brown, Little Rock; E. R. Browning, Hot Springs National Park; J. H. Burge, Lake Village; B. Capes, West Helena; F. W. Carruthers, Little Rock; Alan G. Cazort, Little Rock; Hoyt L. Choate, Little Rock; Eva F. Dodge, Little Rock; S. A. Drennen, Stuttgart; L. T. Evans, Batesville; W. A. Fowler, Fayetteville; S. C. Fulmer, Little Rock; Ellis Gardner,

Russellville; J. G. Gladden, Harrison; D. W. Goldstein, Fort Smith; H. T. Gray, Hughes; W. P. Gray, Batesville; T. S. Hare, Crawfordville; A. H. Hathcock, Fayetteville; L. K. Hundley, Pine Bluff; I. F. Jones, Fort Smith; J. B. Jameson, Camden; O. J. T. Johnston, Batesville; Alfred Kahn, Jr., Little Rock; J. S. Levy, Little Rock; Max F. McAllister, Fayetteville; L. H. McDaniel, Tyronza; J. H. McCurry, Cash; Jim McKenzie, Hope; Max J. Mobley, Russellville; Roy Millard, Russellville; H. E. Mobley, Morrilton; E. C. Moulton, Fort Smith; C. E. Oates, North Little Rock; W. S. Orr, Jr., Little Rock; C. F. Peters, Malvern; J. P. Price, Monticello; Fount Richardson, Fayetteville; G. D. Royston, Hope; W. A. Reilly, Little Rock; J. M. Sadler, Little Rock; B. N. Saltzman, Mountain Home; E. M. Smith, Hot Springs National Park; H. T. Smith, McGehee; J. G. Stuckey, Jr., Lepanto; A. H. Tribble, Hot Springs National Park; H. King Wade, Hot Springs National Park, and B. B. Wells, Little Rock.

T. E. Buffington has been elected mayor of Benton.

Fellowship in the American College of Surgeons was conferred on the following at the recent Boston session: B. T. Kolb, Little Rock; J. H. Pinson, Jr., El Dorado, and Jack Wright, Hot Springs National Park.

R. E. Crigler has been elected treasurer of the Fort Smith Kiwanis club.

Among those attending the Boston session of the American College of Surgeons were: B. L. Moore, A. D. Cathey and J. H. Pinson, Jr., El Dorado; H. A. Causey, Pine Bluff; T. P. Foltz, Fort Smith, and Jos. F. Shuffield, Carl A. Rosenbaum, James Growdon, Paul Hoover and H. Fay H. Jones, Little Rock.

"The Months Ahead," by R. B. Robins, Camden, appeared in The Journal of the Tennessee State Medical Association, October, 1950 issue.

Among those in attendance at the recent Chicago session of the American Academy of Ophthalmology were K. W. Cosgrove, Little Rock; W. J. Schwarz, Little Rock; E. C. Moulton, E. C. Moulton, Jr., L. M. Henry and S. C. Faier, Fort Smith; John W. Dodson, Hot Springs National Park, and Max Baldridge, Texarkana.

A practical course for resuscitation of patients will be offered each month, November through March, under the sponsorship of the Cleveland Heart Society. The course will extend over three days and those interested in enrolling may secure additional information by writing The Executive Secretary, Cleveland Heart Society, 613 Public Square Building, Cleveland 13, Ohio.

Hayden C. Nicholson has assumed his duties as Dean, University of Arkansas School of Medicine.

Sam Phillips, Little Rock, attended the recent Chicago session of the American Academy of Pediatrics.

Paul Mahoney, Little Rock, attended the recent Chicago session of the American Academy of Ophthalomology and Otolaryngology.

R. H. Willett has been elected a director of the Chamber of Commerce at Jonesboro.

Grover Poole has been chosen chairman, and P. W. Lutterloh, member, of the Jonesboro Board of Health.

Fred Ferguson, formerly of Nashville, is taking a residency in urology at Kennedy Hospital, Memphis.

PROCEEDINGS OF SOCIETIES

The Pulaski County Medical Society was addressed November 6th by Hugh A. Browne, "The Management of Pulmonary Tuberculosis at McRae Sanatorium."

Edwin F. Gray, Secretary.

Members of the Arkansas Medical Society are invited to attend a Sectional Meeting of the American College of Surgeons to be held at the Hotel Statler, Saint Louis, January 22 and 23, 1951.

The Second Fall Clinical Assembly jointly sponsored by the Arkansas Medical Society and the Arkansas Chapter, American Academy of General Practice, was addressed October 27th by Robert Henry, Little Rock, "Newer Aspects of Rheumatic Fever"; George Burch, New Orleans, "The Management of Congestive Heart Failure"; Ellis P. Cope, Little Rock, "Diagnosis and Management of Common Skin Diseases"; C. G. Sutherland, Little Rock, "Abruptio Placenta"; I. Meschan, Little Rock, "Radioactive Isotopes"; J. H. Pratt, Rochester, Minnesota, "The Acute Abdomen"; Paul L. Mahoney, Little Rock, "Office E. E. N. T."; E. L. Rushia, Little Rock, "Office Anesthesia"; John D.

Olson, Fort Smith, "Office Surgery," and Willis E. Brown, Little Rock, "Office Gynecology."

The First Councilor District Medical Society met at Jonesboro October 19th for the following program: "Poliomyelitis," Clark M. Baker, Paragould; "Thyroid Disease," J. Harry Hayes, Little Rock; "Recent Developments and Treatment of Coronary Heart Disease," Fred W. Harris, and "Urological Problems in Elderly Patients," Grady W. Reagan, Little Rock. The after-dinner address was by Hon. Joe Barrett, Jonesboro.

J. H. McCurry, Secretary.

The Fifth Councilor District Medical Society met in joint session with the Association of Tumor Clinic Staff Members in Arkansas at El Dorado October 19th for the following program: "Tumors of the Kidney: Diagnosis and Management," Harry M. Spence, Dallas, and "Treatment of Cancer of the Face, Mouth and Neck," Charles L. Martin, Dallas. A social hour preceded the evening dinner session.

Craighead-Poinsett County Medical Society met at Jonesboro November 1 with the following scientific program: "Parotid Tumors and Other Tumors of the Neck and Head," Edwin Cocke, Memphis and "Reasons for and Methods of Removing Tonsils and Adenoids," W. Likely Simpson, Memphis.

Pope-Yell County Medical Society met at Russellville November 9 for a discussion on the Arkansas welfare program by Earle Hunt, Clarksville, and Mrs. Henry Bethel of Little Rock, State Welfare Director.

An inter-professional meeting of physicians, dentists and druggists was held at Camden November 2 with speakers as follows: Fred W. Harris, Little Rock, "British Health Care"; J. D. Jordan, Little Rock, "Dentist of the Half-Century in Arkansas"; Chas. R. Henry, Little Rock, "Legislative Matters," and O. L. Daily, Jr., Little Rock, "The Pharmacist."

The Third Councilor District Medical Society met at Stuttgart November 9 for the following program: "Newer Aspects of Rheumatic Fever," Robert L. Henry, Little Rock; "Signs and Symptoms of the Acute Abdomen," Gilbert O. Dean, Little Rock; "What Is Being Done About Arthritis at Present," J. H. Hamilton, Memphis, and "Office Gynecology," Willie E. Brown, Little Rock. A business session and dinner followed the afternoon scientific session.

WOMAN'S AUXILIARY NEWS

The Hempstead County Medical Auxiliary met September 19th at the home of Mrs. James W. Branch for the first meeting of the year with eight members present. Mrs. Branch, President, presided over the business meeting.

Mrs. Jim McKenzie read an article from the American Medical Journal, which was addressed to Democratic party leaders about the "Blue Shield Medical Plan."

A booth was planned for the Rodeo Show, September 25th, to hand out pamphlets against Socialized Medicine.

Mrs. George H. Wright.

Mrs. T. Duel Brown, President, has announced that the Woman's Auxiliary to the Pulaski County Medical Society will hold its first fall meeting October 18th at the auditorium of the YWCA.

Guest speaker will be Mrs. Warren S. Riley, El Dorado, President of the Woman's Auxiliary to the Arkansas Medical Society.

Other officers who will serve with Mrs. Brown are: Mrs. Gordon P. Oates, President-elect; Mrs. J. Harry Hayes, First Vice-President; Mrs. Ben D. Means, Second Vice-President; Mrs. E. L. Wilbur, Recording Secretary; Mrs. Paul M. Fulmer, Treasurer; Mrs. Alfred Kahn, Jr., Publicity Secretary; Mrs. James Newbill, Corresponding Secretary; Mrs. N. T. Hollis, Historian, and Mrs. Mason Lawson, Parliamentarian.

Hostesses for the first meeting will be Mrs. Leo Aday, Mrs. E. J. Easley, Mrs. Charles Wickard, Mrs. John G. Watkins, Jr., Mrs. H. H. Donahue, and Mrs. Melvin McCaskill.

Mrs. Alfred Kahn, Jr.,
Publicity Secretary.

Mrs. Warren S. Riley, State President of the Woman's Auxiliary to the Arkansas Medical Society, presided at the Fall Board meeting October 11th at Hotel Marion in Little Rock. Twenty-eight members were present. The following Nominating Committee was elected: Mrs. Louis K. Hundley, Mrs. R. C. Dickinson, Mrs. J. K. Donaldson, Mrs. P. W. Lutterloh, and Mrs. Alfred Hathcock. Following reports from each of the Officers and Committee Chairmen a luncheon was held.

The Auxiliary to the Southeast Arkansas Medical Society met in Crossett at the Country Club September 18th. After dinner with the Doctors the ladies adjourned to an adjoining room. The meeting was called to order by the President, Mrs. Lewis Hyatt. Minutes were read and approved.

Under old and new business, Membership and "Today's Health" Chairmen were discussed. It was decided that the Secretary be the Membership Chairman. The other Chairman was not selected. Booths at the County Fair displaying literature against Compulsory Health Insurance was discussed.

There being no further business the meeting adjourned and an enjoyable social hour followed. There were fourteen present. Mrs. Scott Hamilton and Mrs. N. Clam both of Monroe, Louisiana, were among the guests.

Mrs. Van C. Binns.

The Annual Conference for Presidents and Presidents-elect will be held in Chicago November 2nd and 3rd at the LaSalle Hotel. The Conference is held in conjunction with a meeting of the Board of Directors of the Woman's Auxiliary to the American Medical Association.

Mrs. Mason G. Lawson, Second Vice-President of the Woman's Auxiliary to the American Medical Association will attend the Conference for Presidents and Presidents-elect, to be held in Chicago November 2nd and 3rd.

The Woman's Auxiliary to the Jefferson County Medical Society opened their autumn meeting with a luncheon in the home of Mrs. T. J. Cunningham, Jr., with Mrs. Ross Maynard as co-hostess. The home was decorated throughout with white and yellow dahlias and pink gladiolus.

Mrs. Warren S. Riley of El Dorado, President of the Woman's Auxiliary to the Arkansas Medical Society was the guest speaker.

The following Committee Chairmen gave reports: Program, Mrs. Clyde Hart, Jr.; Public Relations, Mrs. Charles W. Reid; Education, Public Health and Cancer Control, Mrs. Fred Hames; Extension of Medical Care and Legislation, Mrs. Louis K. Hundley; Finance, Mrs. James T. Rhyne. Fifteen members and three guests were present.

Mrs. T. J. Cunningham, Jr.,
Publicity Secretary.

The Woman's Auxiliary to the Union County Medical Society met October 4th for luncheon in the club room of the Randolph Hotel. There were sixteen members and one guest present. Yearbooks were distributed by Mrs. Gardner Landers, Vice-President. The yearbooks were dedicated to Mrs. Warren S. Riley, President of the State Medical Auxiliary.

Mrs. J. H. Pinson gave a report of the Exhibit which we had at the county Fair recently. After the transaction of routine business Mrs. Warren S. Riley gave a report on President Truman's Health Program.

Mrs. James O. Cooper,
Corresponding Secretary.

Columbia County Medical Auxiliary had a joint meeting with the Medical Society on September 28th.

During the business meeting a benefit bridge party was planned to raise money for adding a room to the City Hospital in Magnolia. A booth was planned for the County Fair, October 15th thru 21st, to distribute literature against Compulsory Health Insurance.

Mrs. Howard Kitchens.

The Pope-Yell County Medical Auxiliary met October 12th in the home of Mrs. Watson Miller, with nine members present.

The meeting was presided over by the President, Mrs. Watson Miller. A report was given on our booth at the Pope County Fair held last month. Plans were discussed on sponsoring a First-Aid Station at the fair next year.

The magazine committee reported that St. Mary's Hospital received a large donation of magazines last month. Each Auxiliary member saves magazines and during the month they are delivered to St. Mary's for the patients. We also supply comic books for the needy children.

Discussion followed on plans for Doctor's Day and the biography of some doctor in Pope County. The meeting adjourned.

Mrs. Max Mobley, Reporter.

The Woman's Auxiliary to the Sebastian County Medical Society held a luncheon meeting November 13th at the McCartney House. Mrs. W. L. Shippey, President, presided and a round-table discussion was held on aspects of the Blue Cross-Blue Shield program in Arkansas.

Mrs. E. C. Moulton, Jr.,
Publicity Chairman.

The First Councillor District Medical Society and Auxiliary held their 96th Semi-Annual meeting Thursday, October 19, at Hotel Noble in Jonesboro.

The ladies met at the home of Mrs. Paul Stroud, President of the Craighead-Poinsett County Medical Auxiliary, for a Tea and Book Review. Mrs. Knight Laird of Jonesboro gave a review of "The Doctor Wears Three Faces," by Mary Bard, which was most enjoyable.

The ladies joined the doctors for dinner at the

hotel. Honorable Joe Barrett of Jonesboro gave the dinner address.

The Craighead-Poinsett County Medical Auxiliary met Wednesday, November 1, at Hotel Noble. After dinner the ladies adjourned to the Pine Room for their business meeting. In the absence of Mrs. Paul Stroud, President, Mrs. Grover Poole, Vice-President, presided. Miss Florence Stuck, Commander, Craighead County Cancer Society, spoke to the group on the Cancer Program. Twelve members and two guests, Miss Stuck and Mrs. L. Simpson of Memphis were present.

The Auxiliary to the Sevier County Medical Society met at Hills' on October 12th at 1:00 p. m. for a luncheon and business meeting.

The President, Mrs. Pierre Redman, presented the goal chart and all items were discussed and plans made to meet the requirements. Special plans were made for radio broadcast.

Mrs. Charles N. Jones, Program Chairman, gave an outline of the year's program. Eight members were present.

Mrs. Pierre Redman, President.

The Woman's Auxiliary to the Union County Medical Society held their regular monthly meeting Wednesday, November 1, in the Club Room of the Randolph Hotel. The hostesses were Mrs. A. D. Cathey, Mrs. E. J. Munn, Mrs. P. H. Muse of Junction City and Mrs. James Moseley of Hampton.

Mrs. L. E. Fitch gave a brief report on legislation concerning the medical profession. The name of a candidate for the Nurse's Student Loan Fund was presented. Provisions of the loan were read and discussed, after which a vote was taken and the student accepted. Mrs. Gardner Landers gave a brief discussion on the 12-point program of the A.M.A. Members of the Auxiliary are taking an active part in the Tuberculosis Seal Drive.

We had fifteen members and one guest present.

Mrs. J. O. Cooper,
Corresponding Secretary.

The Woman's Auxiliary to the Jefferson County Medical Society held its regular monthly meeting November 10, at the Hotel Pines.

Mrs. Howard S. Stern presided. Mrs. Louis K. Hundley, Legislation Chairman, introduced the guest speaker, State Senator Lawrence Blackwell, Pine Bluff, who addressed the group on the doctors' responsibility in government. Pointing out the increased centralization in government, Senator Blackwell suggested that individual interest in voting was the first step toward combatting socialistic trends. A courageous stand against deficit spending, bureaucracy and government controls is every citizen's responsibility, he declared.

Those present were Dr. and Mrs. Louis K. Hundley, Dr. and Mrs. Ross E. Maynard, Dr. and Mrs. R. D. Dickins, Mrs. John Walker, Dr. and Mrs. R. E. Glasscock, Dr. and Mrs. J. Clyde Hart, Jr., Dr. and Mrs. C. W. Reid, Mrs. T. J. Cunningham, Jr., Mrs. H. J. Morris, Dr. W. H. Bruce, Mrs. John S. Jenkins, Dr. and Mrs. Fred Hames, Mrs. George Talbot, Dr. and Mrs. S. C. Monroe, Mrs. Hunter A. Causey, Dr. and Mrs. H. S. Stern.

Mrs. Glasscock was welcomed as a new member.

The luncheon table was beautifully decorated with yellow and bronze mums.

Mrs. T. J. Cunningham, Jr.,
Publicity, Secretary.

BOOK REVIEW

Brucellosis (Undulant Fever): Clinical and Subclinical. By Harold J. Harris, M.D., F.A.C.P., with the assistance of Blanche L. Stevenson, R.N. Second edition. 617 pages, illustrated. New York: Paul B. Hoeber, Inc., 1950. Price $10.00.

This is a practical discussion and presentation of a disease which has become of increasing importance. The differential diagnosis is stressed. The section on treatment gives the usage of aureomycin and chloromycetin. This is an excellent work and will serve well the physician interested in the differentiation of the many conditions which simulate undulant fever.

Medical Diagnosis—Applied Physical Diagnosis: Edited by Roscoe L. Pullen, M.D., F.A.C.P., Professor of Graduate Medicine, Director of the Division of Graduate Medicine, and Vice Dean of the School of Medicine, Tulane University of Louisiana; Senior Visiting Physician, Charity Hospital of Louisiana at New Orleans; Consultant in Medicine, Veterans Administration Hospital, New Orleans, Louisiana; Consultant to the Surgeon General, Department of the Army, Washington, D. C. Second edition. 1,119 pages with 601 figures, 48 in color. Philadelphia and London: W. B. Saunders Company, 1950. Price $12.50.

New chapters have been added in the revision of this text such as diagnosis of the aged, the sterility problem, occupational injury and others. It is the purpose of the volume to present methods in diagnosis of greatest value to the general practitioner. The purpose is well attained.

A Textbook of Gynecology: By Arthur Hale Curtis, M.D., Emeritus Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; and John William Huffman, M.D., Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School; Attending Gynecologist, Passavant Memorial Hospital, Chicago. Sixth edition. 799 pages with 466 illustrations, chiefly by Tom Jones, including 37 in color. Philadelphia and London: W. B. Saunders Company, 1950. Price $10.00.

An excellent book on the subject, carefully revised in

this sixth edition. Medical and surgical phases are well covered. The illustrations are of unusual value.

Proceedings of the First Clinical Acth Conference: Edited by John R. Mote, M.D., Medical Director, Armour Laboratories. 624 pages, 414 illustrations. Philadelphia: The Blakiston Company, 1950. Price $5.50.

The effects of pituitary adrenocorticotrophin (ACTH) on a wide variety of diseases are reported, the clinical studies necessarily brief and small in number. Primarily, the investigator will be interested in this book and will find it of greater value than will the practicing physician.

Medical Gynecology: By James C. Janney, M.D., F.A.C.S., Associate Professor of Gynecology, Boston University School of Medicine; Associate Visiting Gynecologist, Massachusetts Memorial Hospital. New, second edition. 454 pages with 108 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $6.50.

This second edition is solely medical in its approach to gynecologic problems. Procedures applicable in home and office management are discussed in proper detail.

A Primer for Diabetic Patients—An Outline of Treatment for Diabetes with Diet and Insulin including Directions and Charts for the Use of Physicians in Planning Diet Prescriptions: By Russell M. Wilder, M.D., Ph.D., F.A.C.P., Professor and Chief of the Department of Medicine of the Mayo Foundation, University of Minnesota; Senior Consultant in the Division of Medicine, Mayo Clinic. New, ninth edition. 200 pages with 8 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $2.25.

The value of this excellent little book is shown by its appearance in this, the ninth edition. It contains important and helpful information for diabetics and their physicians.

An Atlas of the Blood and Bone Marrow: By R. Philip Custer, M.D., Director, Laboratories of the Presbyterian Hospital in Philadelphia; Assistant Professor of Pathology, The University of Pennsylvania School of Medicine; Consultant to the Armed Forces Institute of Pathology. 321 pages with 285 figures, 42 in color. Philadelphia and London: W. B. Saunders Company, 1949. Price $15.00.

This book is one which endeavors to assist in more accurate blood study and its 42 color photomicrographs are most valuable. The accompanying text is clear and concise. The hematologist will find this a most helpful volume.

Primer of Allergy: By Warren T. Vaughn, M.S., M.D., with illustrations by John P. Tillery. Third edition, revised by J. Harvey Black, M.D. Saint Louis: C. V. Mosby Company, 1950. Price $3.50.

This book is for the education of the patient and gives the fundamentals by discussion, questions and answers and cartoons in addition to directions and instructions.

A Textbook of X-ray Diagnosis: By British Authors in Four Volumes. Second edition. Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director, X-ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Director, X-ray Department, Westminister Hospital; Radiologist, Royal Chest Hospital, London. Volume IV. 592 pages, 553 illustrations. Philadelphia and London: W. B. Saunders Company, 1950. Price $15.00.

This volume is the first of the set of four appearing as a second edition. The illustrations are numerous and well reproduced as positives. Typography is such as to promote reading ease. The subject material is concisely presented yet extensive in its coverage. It will prove most popular with radiologists who desire a comprehensive, authoritative text.

A Manual of Cardiology: By Thomas J. Dry, M.A., M.B., Ch.B., M.S. in Medicine; Associate Professor of Medicine, University of Minnesota (Mayo Foundation); Consultant in Section on Cardiology, Mayo Clinic. New, second edition. 355 pages with 97 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $5.00.

This book should prove of particular assistance as a quick reference work and will give the physician in general practice who studies its pages an excellent understanding of heart disease without burdening him with many theories or redundancies in writing.

Postgraduate Gastroenterology—As Presented in a Course Given Under the Sponsorship of the American College of Physicians in Philadelphia, December, MCMXLVIII: Edited by Henry L. Bockus, M.D., Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine. 670 pages with 258 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $10.00.

This comprises the course given under sponsorship of the American College of Physicians in which some fifty authorities participated. Recent advances in the diagnosis and treatment are well covered as well as controversial subjects, the latter presented with both the for and against side.

Proctology in General Practice: By J. Peerman Nesselrod, B.S., M.S., M.Sc. (Med.), M.D., F.A.C.S., F.A.P.S., Associate in Surgery, Northwestern University Medical School; Associate of Surgical Division of Proctology, Evanston Hospital, Evanston, Ill.; Certified by the Central Certifying Committee in Proctology (Founders' Group) of the American Board of Surgery; Commander (MC), USNR. 276 pages with 64 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $6.00.

This book is planned for the general practitioner and describes techniques and treatments which are most commonly required in an office practice. The illustrations are excellent.

Blakiston's New Gould Medical Dictionary: Edited by Harold W. Jones, M.D.; Normand L. Hoerr, M.D., Ph.D., and Arthur Osol, Ph.D. 1,294 pages, 252 illustrations, 129 in color. Textbook edition. Philadelphia: The Blakiston Company, 1949. Price $8.50.

This is a new medical dictionary and is both modern and complete. Pronunciation is given by phonetic respelling, and alternate pronunciations are offered. Type is large and separate entries are bold faced with marginal delineations. It is a practical, comprehensive, workable reference book.

Electrocardiography—Fundamentals and Clinical Application: By Louis Wolff, M.D., Visiting Physician, Consultant in Cardiology and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; Associate in Medicine, Harvard Medical School. 187 pages with 110 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $4.50.

Electrocardiography in its basic principles is presented by the method which has proved its worth to the author in teaching. The application of the principles to interpretation completes an excellent text on this subject.

Primer of Allergy: Warren T. Vaughn and J. Harvey Black. C. V. Mosby Company, St. Louis, Missouri, $3.50.

The Primer of Allergy, written by Dr. J. Harvey Black of Dallas, and the late Dr. Warren Vaughn of Richmond,





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—Council an Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. 143:815 (July 1) 1950.

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has gone through three editions as "a guidebook for those who must find their way through the mazes of this strange and tantalizing state." In prefaces to the first two editions, the authors stress the utilitarian purpose of the book, the incorporation in a single volume of pertinent information about allergy for physician and patient alike. The third edition is frankly "a bedtime story for the lay reader." Technical knowledge for the physician is relegated to a larger volume, The Practice of Allergy, by the same authors.

The primer employs a chatty newspaper style which cloaks advice on such subjects as: the allergic constitution, recognition of allergic symptoms, causes of their continuance and chances for their relief; needed cooperation between physician and patient. Under a chapter headed ABRACADABRA, the authors debunk many popular misconceptions about allergy through lucid explanations of terms used in the field. Several chapters are devoted to the development of a complex figure of speech in which the human body is compared to the State of Allergy, with invasions by enemy allergens and home defense by shock tissues, antibodies, reagin. This device, worked out in minute detail with military phraseology, is explained as being more imaginative than scientific, but it fulfills its purpose of clarifying the fundamentals of Allergy. The real value of this short study lies in such practical compendia as the following: The question and answer section at each chapter's end; directions for keeping food and inhalant diaries; analytical tables of food content; botanical classifications of edible foods, and a utilitarian section entitled General Orders.

This latter encompasses directions to patients on such subjects as: pollen hay fever, allergic eczema, headache and colitis; house dust and cosmetic sensitivity and their treatments, and various aspects of food allergies.

Dr. Vaughn, one of the pioneers in Allergy, and Dr. Black, long a successful practitioner in the field, have condensed a great deal of practical information in the primer, both for the patient, the lay reader and the general practitioner. The book is concise common sense about a subject called by the authors, not so much a disease as an idiosyncrasy.—Alan G. Cazort, M. D.

Clinical Biochemistry: By Abraham Cantarow, M. D., Professor of Biochemistry, Jefferson Medical College; and Max Trumper, Ph.D., Commander, H(S), USNR. Lecturer in Clinical Biochemistry and Basic Science Coordinator, Naval Medical School National Naval Medical Center, Bethesda, Maryland. Fourth Edition. 642 pages with 38 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $8.00.

Most physicians recognize the fundamental contributions of biochemistry to the diagnosis and treatment of disease. In attempting to understand the rapid advances in biochemical knowledge, they are discouraged by the multitude of papers in the literature based on observations of a highly specialized and technical nature. This book offers an up-to-date and easily understood summary of biochemical knowledge which is translated into its clinical applications.

The busy practitioner will want to keep "Clinical Biochemistry" at hand for ready reference because it explains many clinical problems simply and clearly. Starting from the data presented by the patient, reference to this book will help explain the metabolic abnormality, suggest further laboratory studies, indicate rational therapy, and specify the significance, limitations, and interpretation of these studies. It is devoted to the interpretation of clinical and laboratory data, not to laboratory methods. The material is conveniently arranged for reference. The index is detailed and excellent. Bibliographies at the end of each chapter are brief but direct attention to the most significant recent articles and reviews.

The following topics are among the newly added material in the fourth edition: chemical changes in shock; thymol turbidity and flocculation; fatty liver; lower nephron nephrosis, potassium in the treatment of diabetic coma, alarm reaction, and new methods of studying the adrenocortical function. Extensive revisions have been made in sections on the regulation of acid-base balance; pigment metabolism in relation to jaundice, renal physiology, carbohydrate, lipid, protein, and iron metabolism. Numerous tables and diagrams add to the clarity of presentation. The extensive experience of the authors enables them to give a critical evaluation of the limitations and significance of laboratory tests. The physician who refers to this book should be able to use the laboratory more effectively.

The Management of Obstetric Difficulties—By Paul Titus, M.D. Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Shadyside Hospital, Pittsburgh; Secretary of the American Board of Obstetrics and Gynecology; Member Reserve Consultants Advisory Board, Bureau of Medicine and Surgery, United States Navy (Captain, MC, USNR). Fourth Edition, St. Louis, C. V. Mosby Company, 1950.

The fourth edition of Titus' Management of Obstetric Difficulties has been enlarged and revised to include the many new developments in obstetric practice since the last edition in 1945.

One of the outstanding features of the book is the attempt made to standardize terminology in obstetric practice. Drs. J. P. Greenhill and Nicholson J. Eastman met with Dr. Titus to consider and adopt uniform terms, classifications and procedures in obstetric management. Dr. C. O. McCormick also adopted these terms in his recent book. Examples of these suggestions are the classification of placenta previa into total and partial rather than central, marginal, etc. Low implantations of the placenta are no longer classed as types of placenta previa. Low, mid, and high forceps as well as "stations" of the presenting part are specifically defined.

An excellent chapter on X-ray mensuration and appraisal of pelves is included. External caliper measurements of the pelvic inlet are abandoned in favor of the more accurate X-ray measurements. The study and treatment of sterility is revised. Very practical discussions of management and treatment of placenta previa, toxemia of pregnancy, and hemorrhage and shock are given.

The sections of the book are headed (1) Sterility, (2) Difficulties in diagnosis of pregnancy, (3) Complications of pregnancy, (4) Complications of labor, (5) Obstetric operations, (6) Complications of the puerperium, (7) Newborn infant, and (8) General. The latter section includes preparations for operations, post partum and post operative care of the patient, and excellent discussions of obstetrical analgesia and anesthesia and intravenous infusions and transfusions. Dr. Titus has admirably fulfilled the chief purpose of his book as set out in the preface to the first edition, "to provide swiftly available information to supplement one's judgment respecting the proper management of emergencies."

There are 1046 pages in the text including a complete index of 30 pages.

JAN 18 1951
San Francisco, 22

The Journal of the Arkansas Medical Society

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High Vitamin B_{12} Content... Another Reason for Liberal Meat Intake

According to rapidly accumulating clinical and laboratory observations, the daily ingestion of liberal quantities of meat can effect profound physiologic benefits due to the significant content of vitamin B_{12}, not only in liver and kidney, but also in muscle meats.

Muscle meat is a good source of the newly isolated vitamin B_{12}; liver and kidney are especially high in their vitamin B_{12} content, while plant foods are negligible sources of this nutrient.[1] By rat assay, the minimum amounts of vitamin B_{12} in muscle meat range from 0.5 to 3 mcg. per 100 Gm.; minimum values for beef liver and kidney are 15 and 20 mcg., respectively.[2]

B_{12} is among the most potent of known microbiologically active substances.[3] Animal studies indicate that it increases the ability of the normal mammal to utilize protein.[4] With a high protein diet, 0.01 mcg. of vitamin B_{12} per day was found to increase significantly the growth rate of B_{12} deficient rats. In another study, growth response of B_{12} depleted rats was proportional to the B_{12} in the ration within the critical range of 0.025 to 0.1 mcg. per rat day.[5]

About 1 mcg. of vitamin B_{12} daily, administered intramuscularly, constitutes an effective dose in pernicious anemia. In a recent clinical study of young children manifesting vitamin B_{12} deficiency as evidenced by malnutrition and growth failure, oral administration of 10 mcg. of vitamin B_{12} daily for eight weeks induced marked responses in growth; notable increases in vigor, alertness and better general behavior; and improved appetite.[6]

Here again is further evidence of the broad, over-all nutrient contribution meat makes to the dietary. Eaten two or three times daily, it supplies not only generous amounts of high quality protein, but also significant quantities of vitamin B_{12} and other essential B complex vitamins, and of iron.

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(4) Hartman, A. M.; Dryden, L. P., and Cary, C. A.: The Role and Sources of Vitamin B_{12}, J. Am. Dietetic Assoc. *25*:929 (Nov.) 1949.

(5) Frost, D. V.; Fricke, H. H., and Spruth, H. C.: Rat Growth Assay for Vitamin B_{12}, Proc. Soc. Exper. Biol. & Med. *72*:102 (Oct.) 1949.

(6) Wetzel, N. C.; Fargo, W. C.; Smith, I. H., and Helikson, J.: Growth Failure in School Children as Associated with Vitamin B_{12} Deficiency—Response to Oral Therapy, Science *110*:651 (Dec. 16) 1949.

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CONSERVATISM IN GYNECOLOGY*

E. C. HAMBLEN, M.D., F.A.C.S.
Durham, N. C.

(From the Division of Endocrinology and the Department of Obstetrics and Gynecology, Duke University School of Medicine and Duke Hospital)

The title, 'Conservatism in Gynecology,' was assigned me, when the invitation was extended to address you. I assure you that I would not have assumed voluntarily the role of a censor of conservatism and radicalism. Indeed, the term 'conservatism,' as applied to medicine or politics, is hackneyed and commonly equivocal. Most of us, regardless of our every-day practices and often contrary to the opinion of our colleagues, believe that we are conservative. The term 'conservatism' is applied even to surgeons. The 'conservative surgeon' is apparently one who removes only small portions of organs, preferring to go back for additional fractions. The 'radical surgeon' obviously does the whole job at one time. It has been reported, and I am sure it was meant facetiously or was Northern propaganda, that a few surgeons time their gynecologic surgery with cotton ginning season and gauge its extent by the success of the harvest; a poor crop means only cauterization of the cervix; a better crop usually results in a suspension of the uterus or the removal of the tubes; a bumper crop, however, sometimes results in hysterectomy. Obviously, such a plan of annual surgery of different degrees of intensity might be regarded as conservative, in the sense that the patient was preserved as a source of income. Having reviewed these matters, I question whether surgery is ever conservative, although it may be indicated, skillfully done, and productive of great benefit. Accordingly, Webster's New International Dictionary was consulted for appropriate meanings of 'conservatism' and 'conservative.' Conservatism is defined as 'the disposition and tendency to preserve what is established.' Conservative, as an adjective, is defined as 'having power or tendency to preserve in a safe or entire state.' These definitions, accordingly, exclude surgery as well as irradiation as conservative methods. They destroy function.

Having limited our discussion to our own satisfaction, we now are in a position to extol the virtues of nonsurgical, nonirradiational therapy. We shall view surgery and irradiation as methods which admit failure of conservatism. We hold that the most potent forces for conservatism in gynecologic practice have been, in order of their importance: 1, an expanding knowledge of endocrinological physiology and of endocrinological therapy; and 2, chemotherapy and therapy with antibiotics. These forces have stimulated and implemented more conservatism than the sum total of all other similarly oriented pressures, including gynecologists criticizing surgeons for their pelvic pilferings; pathologists reprimanding both for the removal of normal organs; the lengthening of periods of training for specialization; and the increasing emphasis upon certification by specialty boards. Our discussion shall concern some of the ways in which knowledge of endocrinology has furthered conservatism in gynecology.

A Physiologic Approach to Gynecology

Many of us remember when one of four diagnoses could be expected from curettings sent to pathologists; namely, 'normal endometrium,' 'endometritis,' 'incomplete abortion,' and 'carcinoma.' A normal endometrium was diagnosed when it was similar to ones now recognized as interval or estrogenic. A progestational endometrium was regarded as indicative of 'endometritis,' frequently being diagnosed specifically as 'glandular endometritis.' It is surprising that the concept of a normal cycle of endometrial growth and differentiation was accepted so slowly. These former endometrial 'diagnoses' not only failed to afford means of identifying functional disturbances but they fostered the belief that normal preparation of the endometrium for nidation of the fertilized egg was infection, that is, 'endometritis.' When I studied obstetrics and gynecology in medical school, our professor circulated among the class carbon copies of an English translation he had made of the original article by Hitschmann and Adler, which had been published

*Read at the annual meeting of the Arkansas Medical Society, Fort Smith, Arkansas, April 17-19, 1950.

in 1908 and which gave histologic descriptions of endometriums at different stages of the ovarian cycle. Our professor doubtlessly felt that, nearly twenty years later, the current textbooks of obstetrics and gynecology did not describe amply these changes. Rereading the section on 'puberty, ovulation, and menstruation' in chapter I of the text on obstetrics which I studied 25 years ago, a statement is noted that the cause of menstruation is still unknown and that the most generally accepted theory is that during ovulation the ovary exerts some sort of influence which, upon reaching the uterus, causes a severe congestion and subsequent menstruation.

Approximately 30 years ago a series of epochal studies began; these were destined to be the foundations for our present concepts of gynecic physiology and of gynecologic endocrinology. Of course, there had been clinicians before this time who talked of endocrinology and who used dried pituitary gland and desiccated whole ovary or corpus luteum to treat females but, for the most part, these were 'endocriminologists.' They only incriminated the endocrine glands, being unable to diagnose generally disturbances of these glands; unfortunately, there are still a few 'endocriminologists' amongst us. Some of these important contributions are briefly cited: Stockard and Papanicolaou in 1917 demonstrated characteristic changes in the vaginal epithelium of animals during the estrous cycle; (many gynecologists have discovered Papanicolaou during the past 5 years and have grown quite familiar with his studies of vaginal cytology); R. T. Frank in 1923 described hyperplasia comparable to that of estrus in the genitalia of castrated animals which had received injections of a lipid ovarian extract; Edgar Allen and Doisy in the same year reported that injections of an extract from the follicular fluid of pigs' ovaries produced estrus in castrated and immature mice when judged by studies of vaginal smears; Allen, Pratt and Doisy in 1925 identified estrogens in human ovarian follicles; Philip Smith in 1927 proved conclusively that hypophysectomy caused atrophy of the gonads and that this atrophy was prevented by pituitary grafts; Hisaw in 1928 prepared active corpus luteum extracts; Aschheim and Zondek in 1928 established gonadotropic activity of pregnancy urine; Doisy and associates in 1929 recovered estrone, the first estrogen, from pregnancy urine; and, in the same year, Engle showed that castration increases the gonadotropic activity of the pituitary and questioned that the gonadotropins, identified by Aschheim and Zondek in pregnancy urine, were of pituitary origin. Thus, in a short period of approximately 10 years we were supplied with objective data on gonadotropins, estrogens and progestin, which were the basis for an understanding of endocrinologic physiology. Subsequently, within a quite short time, purified preparations of these hormones were available for therapy. Endocrine therapy, at first, was exploited to a great degree without secure diagnostic foundation. There now exist, however, adequate clinical methods for the evaluation of ovarian function.

It seems proper to take a brief inventory of our knowledge of gynecologic endocrinology which has implemented conservatism by favoring a physiologic approach to many problems of women. The endocrine system is closely related to the nervous system, both at the level of the pituitary gland, by fibers from the hypothalamus and by fibers from the Vidian ganglion, and at the level of the adrenal medulla. Nervous impulses alter the function of the various endocrine glands and in turn activities of the endocrine system alter the workings of the nervous system. Studies here at Duke University by Markee and his associates in the Department of Anatomy have established hypothalamic regulation by adrenergic substances of gonadotropic secretion by the pituitary gland. Recently, the secretion by the pituitary of adrenocorticotropin (A. C. T. H.) has been shown to be influenced by epinephrine. The ovaries and the adrenal glands, accordingly, are influenced by neural impulses. The same is doubtlessly true for the thyroid. The adaptational syndrome of Selye emphasizes in a spectacular way the alterations which may occur not only in the endocrine system but in nonendocrine systems because of stress. The hormones of the endocrine glands have specific metabolic properties. The metabolic actions of the ovarian hormones often are overlooked because of emphasis upon their sex roles. Thus, metabolism may be altered by emotions and by stress.

Pubescence is due to a physiologic upswing in the gonadotropic activity of the pituitary. This brings about increasing waves of estrogen secretion by the ovaries, which are responsible for the differentiation of the girl into the woman. When pubescence fails to occur at the usual time, investigations may show that there are unusually large amounts of gonadotropins in the individual's urine. This indicates that the cause of the failure of pubescence is an intrinsic failure of the ovaries and it means that the pituitary has tried to stimulate these ovaries by working many times more intensely than normally but without avail. If the

urine of these patients contains little or no gonadotropins, the assumption may be made either that the pituitary is slow in trying to stimulate the ovaries or that the pituitary is incapable of secreting normal amounts of gonadotropins. Thus, diagnoses are made in terms of disturbed physiology.

The ovarian cycle of a postpubescent woman is characterized by reciprocal functions of the pituitary and of the ovaries. Towards the latter part of uterine bleeding, a cluster of ovarian follicles begins to develop. There is an associated outpouring of estrogen which is secreted by the granulosa cells of these follicles and by surrounding theca cells. Estrogen is a growth hormone of the endometrium and, thereby, stimulates a new phase of endometrial growth. When the endometrium begins to grow, it ceases to bleed. Bleeding characterizes endometrial regression. The pituitary shortly begins to supervise ovarian function, as it were. This is done by way of the so-called follicle-stimulating gonadotropin (F. S. H.), which stimulates a so-called 'favored follicle,'—one of the many in the cluster which is destined to mature. F. S. H. monitors its development to the preovulatory stage. There is a correlated increasing secretion of estrogen and a concomitant increasing growth of the endometrium. When development of the follicle is complete, estrogen levels are elevated sufficiently to cause the pituitary to release another hormone, so-called luteinizing gonadotropin (L. H.) or interstitial-cell-stimulating-hormone (I. C. S. H.). This hormone produces ovulation. Following ovulation, there are reorganization of the remaining granulosa cells and proliferation of the theca cells. The granulosa cells, thereby, are changed into lutein cells and, under the influence of L. H. or I. C. S. H., they continue the secretion of estrogen and, in addition, secrete progestin. Endometrial growth, accordingly, progresses due to estrogen secretion and, under the influence of progestin, the endometrium specifically is differentiated for reception of a fertilized ovum. If pregnancy does not occur, degeneration of the corpus luteum begins approximately 10 days after ovulation; and, accordingly, the endometrium regresses due to the decreasing secretion of estrogen. Therefore, the specific cause of endometrial regression is lack of growth stimulation by estrogen. When this regression becomes marked, bleeding occurs and it continues until there is an upswing in estrogenic secretion which is sufficient to initiate a new phase of endometrial growth.

Not all ovarian cycles are characterized by ovulation. Anovulatory cycles may simulate those which terminate in ovulation and menstruation. Development of a follicle may not terminate in ovulation but in gradual regression; there are associated a gradual fall of estrogen levels and bleeding from an interval endometrium. Since these anovulatory cycles do not afford an opportunity for pregnancy, they may cause unwelcomed sterility. A differentiation between ovulatory cycles and anovulatory cycles is relatively easy by studies of basal body temperatures and by studies of endometrial specimens taken by biopsy immediately before or at the onset of bleeding. Basal temperature records, taken throughout the interval between episodes of bleeding, have a characterstic biphasicity in ovulatory cycles. The temperature rises abruptly after ovulation, due to the hyperthermic action of progestin, and this rise is maintained until a day or so before the onset of bleeding. There is no biphasicity in the anovulatory cycle. Thus, by these two relatively simple means, a differential diagnosis of the quality of ovarian function can be made. Anovulatory cycles may be associated with no clinically apparent decrease in estrogen secretion.

The ovaries age more rapidly than woman's other organ systems. Aging of the ovaries causes the climacteric. The ovaries fail in two ways: They become unable to form ova, and they fail to secrete normal amounts of hormones. The cause of the menopause, then, is a progressive hyporeactivity of the ovaries; it occurs when fluctuations of estrogen secretion become insufficient to cause endometrial growth, regression, and bleeding. Anovulatory cycles may precede the menopause for several years. Even after the menopause, the ovaries secrete small but very important amounts of estrogens. Some tissues require much less estrogen for their health and normal physiology than the endometrium for growth and bleeding. As the climacteric ovaries fail, the pituitary increases its gonadotropic activity in an attempt to overcome ovarian refractivity. Therefore, an examination of urine of climacteric and postmenopausal women shows a large content of gonadotropin. This indicates that ovarian failure has occurred despite hyperactivity of the pituitary. Markedly increased gonadotropin content of the urine of a 30-year-old woman with amenorrhea is of poor prognostic import because it indicates a premature menopause. This is a necessary differential diagnosis for patients with postpubescent amenorrhea.

Accordingly, the reciprocities between the various endocrine glands and the relationships of the endocrine and nervous systems, to paraphrase the

old statement about the dog, indicate that woman wags her pelvis rather than the pelvis wagging her. Despite this truism, some gynecologists appear much more familiar with the vulvae of their patients than with their facies, know about a slight sagging of the bladder base but do not know of the connubial crises of the patient; know the exact position of her uterus but have failed to find out that the patient's nervousness and backache may be due to the household drudgery she does in order that her husband can afford to play golf. A careful pelvic examination yields important data but it does not necessarily constitute the major objective of a patient's visit. Regardless of how faithfully the pelvic oracle is consulted, it cannot provide always a diagnosis of what is wrong with woman. Sometimes, as one visits large gynecologic clinics, so much emphasis is placed solely on pelvic examination, one gathers that these clinics have as their primary purpose the screening of patients for surgery and for irradiational therapy. So much seems to be missed in the way of an overall evaluation of the patient and so little attention is given to medical and endocrinological measures. In fact, nurses who work in these clinics seem to catch the spirit. It is difficult at times to see a patient in consultation save with her perineum draped for a pelvic examination, and her head under a sheet. This is indeed a poor rapport for an endocrinological study. It seems that history taking and examination should proceed in a more subtle manner. The basis of any conservatism in gynecology requires a consideration of the patient and not solely performing a pelvic examination. Conservative gynecology is concerned not so much with where the pelvic organs are or how they feel, but with what they do, what they contribute, and whether or not their function is normal.

Conservatism During Pubescence

The pubescent girl commonly finds herself in medicine's No-Man's Land. She is judged too old to go to a pediatrician. She and her mother hesitate to consult a gynecologist for several reasons: Many gynecologists do not welcome the problems of adolescence; the atmosphere of the office of many obstetricians and gynecologists is judged to be somewhat too realistic; and many gynecologists lack the finesse, which the pediatrician usually has, to handle these girls in a satisfactory manner. The result is that pubescent girls either remain under the care of pediatricians, who have accepted pubescence as their responsibility or they are seen by general practitioners, God bless them! Accordingly, the gynecologist by not accepting pubescence or by not handling the pubescent patient to the best advantage, fails to make a significant contribution to conservatism. At this time so much can be done by proper counselling, proper orientation, and the inculcation of basic concepts of physiology, all of which contribute to the development of an understanding woman, appreciative of efforts designed to conserve her gynecologic functions and resistant to offers of needless gynecologic surgery. Furthermore, the proper indoctrination into pubescence minimizes functional disturbances and the psychosomatic manifestations of menstruation.

Pubescence is a time when vagaries of menstrual flowing may be explained to the patient and, accordingly, may be assessed for their true worth. The facts can be pointed out that irregularity of bleeding does not produce ill health, and that, whereas the average norm of length of the menstrual cycle ranges from 28 to 30 days, clocklike regularity of menstruation rarely occurs. Too much endocrine therapy has been directed towards menstrual calendars rather than towards some objective abnormality of woman.

The greatest contribution of endocrinology to gynecologic conservatism has been in the treatment of functional uterine hemorrhage. When depleting hemorrhages occur during adolescence or in young women, two urgent obligations exist: 1, to control the hemorrhage and preclude the further hemorrhages and 2, to avoid any permanent damage to ovarian function. Prior to the establishment of an effective endocrine therapy, these objectives rarely were obtained. Repeated curettages, intrauterine implantation of radium, and too commonly hysterectomy were done. The concept that these hemorrhages result from functional disturbances in estrogen secretion, due to temporary disruptions of the reciprocities between the ovary and the pituitary, has permitted a conservative treatment. When these patients bleed excessively, the cause of the bleeding is a teetering of estrogen secretion at levels which are too low to induce endometrial growth, and, thereby, check bleeding. Oral therapy with estrogens and progestin which mimics normal ovarian function, produces cycles of normal duration and flowing. If these artificial cycles are produced for 3 or 4 months, the ovaries are 'put to rest' for that period of time and the pituitary is subjected to normal and cyclic stimuli. When this treatment is discontinued, the majority of these patients initiate or resume not only cycles which are normal

in duration and flowing, but ones which are characterized by fertility, that is, ovulation. The usual formula for this therapy comprises 3.75 mg. of 'conjugated estrogens' orally per day for 20 days and, during the last 10 days of this 20 days of treatment, oral administration daily of 30 mg. of anhydrohydoxyprogesterone or 30 mg. of progesterone daily by buccal absorption. The treatment is discontinued after 20 days in order that withdrawal bleeding may occur and it is resumed on the 4th or 5th day of withdrawal bleeding. Three or four cycles of this therapy usually are given.

Conservatism During the Reproductive Years

Functional uterine bleeding during the reproductive years should be treated in a fashion similar to that described for the adolescent. One should be certain, however, that bleeding during this time of life is functional. By functional, it is meant that organic causes have been excluded. A careful gynecologic inventory of the patient and a curettage with histological studies of the endometrial specimen usually will identify the common organic causes.

The use of oral estrogens in the treatment of dysmenorrhea by suppression of ovulation may be viewed as conservative if it keeps the patient from having major surgery. It is not conservative if this therapy imposes undesired sterility.

It is our opinion that androgen therapy of woman at any age is hazardous and rarely constitutes conservative practice. It is indicated only when there is proven hypoandrogenism, which is quite rare.

Sterility is a frequent problem. It should be investigated in a proper manner. True conservatism requires investigations of both the husband and the wife. Only an 'endocriminologist' rates the incidence of ovarian sterility higher than that of tubal obstruction. As a matter of fact, less than 5 per cent of the wives of childless couples, who were studied by us, had deficient ovarian function, whereas nearly 50 per cent of them had obstructed tubes. Accordingly, ovarian sterility should be diagnosed by basal temperature records and endometrial biopsy studies rather than by presumption. There is no place for empiric gonadotropic therapy of presumed 'ovarian sterility' in conservative gynecologic practice.

In the cause of gynecologic conservatism, we should like to make a plea that surgeons furnish all women with exact statements of why they were operated upon, what was found, and what was done. This would save much futile guessing by subsequent physicians and would reduce the number of sterility investigations of women with postoperative pelves.

Conservatism may appear at times when it is least expected. I have been gratified by hearing a most eminent surgeon plead for ovarian conservation in the treatment of endometriosis. He urges that, instead of the ovaries being sacrificed because of endometriosis, the endometriosis be excised, regardless of how extensive it is, so that the ovaries may be saved. His reason for wanting to save the ovaries is not primarily for their sex functions but for their metabolic value. He points out that osteoporosis occurs earlier or more frequently in castrated women than in noncastrated women.

Conservatism During the Climacteric

There is reason for conservatism even at this time of life. We believe that functional uterine bleeding of climacteric women should be treated in a similar fashion to that of the adolescent. We do not believe that it is necessary or desirable to implant radium into the uterus of a climacteric woman with prolonged functional bleeding. We think that this hemostasis at times may obscure an undiagnosed endometrial carcinoma. On the other hand, we hold that, had a similar patient been treated with cyclic estrogen and progestin, she would have a recurrence of abnormal bleeding, another curettage and an earlier diagnosis of a carcinoma.

Furthermore, we do not believe that normal ovaries should be removed because a woman is climacteric. Although the menopause has occurred, this does not mean that the ovaries do not secrete estrogens. The ovaries may secrete small but important amounts of estrogens, from a metabolic viewpoint, for many years after the menopause. The incidence of osteoporosis in postmenopausal women is reduced by ovarian conservation. Furthermore, somatic aging is retarded by the estrogen secretion of aging ovaries.

Conservatism, however, does not warrant intensive estrogen therapy during the climacteric. It is possible to maintain uterine size and to continue withdrawal bleeding in a cyclic fashion and in amounts comparable to that of menstrual bleeding for indefinite time by full substitutional therapy with estrogens. By so doing, the climacteric can be forestalled, save for ovarian failure and sterility.

Conservatism, likewise, does not sanction estrogen therapy for all climacteric women. This therapy is indicated for the distressing vasomotor symptoms of a minority in whom the climacteric

process seems to be more critical than usual. These stem from undue stimulation of the thyroid and of the adrenal medulla, incidental to overactivity of the pituitary. Estrogen therapy should aim at palliation and not euphoria. Dosage levels should not simulate those of full substitutional therapy, otherwise the course of the climacteric is slowed. All therapy should be of limited duration, which should not exceed six months. It should be given orally and cyclically: Estrogens are given for 20 days and then withdrawn for 10 days; therapy is adjusted to the ovarian cycles of premenopausal women. 1.25 mg. of conjugated estrogens per day usually suffice and this amount should be reduced gradually after a few months. The daily dosage of estrogen for postmenopausal women should not exceed 0.625 mg. of conjugated estrogens and therapy also should be given cyclically. When therapy is given more intensively, bleeding may return. When this occurs, it arouses fear in the patient and apprehension of the physician, and usually leads to a curettage. This is, indeed, a poor way of palliating a climacteric woman!

Infrequent injections of large amounts of estrogens during the climacteric are wholly unphysiologic. Too many patients receive injections at varying lengths of time, too frequently determined by their desires or by the willingness of office nurses. This form of therapy constitutes an ideal formula for keeping the endocrine system in an indefinite state of chaos and flux. It constitutes a fairly sure method maintaining a climacteric crisis.

Summary

Some aspects of conservatism in gynecology have been discussed. An expanding knowledge of endocrinology and of endocrinological therapy has implemented conservatism. The cause of conservatism will profit further by more attention to a thorough study of the patient and less emphasis of the surgical side of gynecology.

A postgraduate course in "Fundamentals of Electrocardiography" will be held at The University of Oklahoma, School of Medicine, Oklahoma City, Oklahoma, February 19th through 24th. Doctor Robert Bayley, Professor of Medicine, at The University of Oklahoma, School of Medicine, will conduct the course. The fee for the course will be $60. Information concerning registration can be obtained from the Office of Postgraduate Instruction, University of Oklahoma, School of Medicine, 801 N. E. 13th Street, Oklahoma City, Oklahoma.

MEDICAL PLANNING FOR ATOMIC DISASTER*

Col. William L. Wilson, Medical Corps, United States Army, Washington, D. C.

Special Assistant to The Surgeon General, Department of the Army

So much has already been said that it may be impossible to introduce many new thoughts concerning the atomic bomb. There have been numerous and widely published technical truths and half-truths, as well as perhaps excessive or unreasonable publicity. We physicians, therefore, are justified in recognizing some temporary pessimism until we confirm our capabilities for overcoming the hazards attributable to atomic bombing.

Effective Medical Planning

My objective shall be to point up the truths here and now. We should start with a determination to apply only that information we may obtain from recognized technical authorities. Thus prepared, we may support more confidently those administrative measures necessary to assure maximum survival along with minimum permanent damage to individuals and communities. Perhaps too few of us have done enough along that line. May we not increase our own and the public confidence by planned and organized activities of all of our health services, based upon simple detail and the means that will be available to us in the event of atomic disaster?

Medical planning for atomic disaster will have active public interest and support at all times if it is undertaken intelligently. At the same time we are attending to our own plans, we may stimulate that public support by proper publicity along the following lines:

We must justify the public confidence by consistent advance of our own knowledge of the organized response required for restoring or maintaining health in the event of atomic attacks.

We must impart the acquired facts to the people in understandable form to permit their active participation in our earliest medical planning.

We must conduct active educational programs which will tell all of the people what to expect if attacked, what to do and when, and how to do those things sure to benefit them and their health. As a result of effective medical plan-

*Reprinted, with permission, from The Journal of the Florida Medical Association, October, 1950.

ning along these lines interim periods of cold war, psychologic warfare before or during open hostilities, and active enemy attacks against our civilian communities should all be doomed to ultimate failure from their earliest inception.

It would be impossible to exaggerate the benefits guaranteed by public confidence that prompt and skilled medical services will be available at all times for repair of individual illness and injury brought on by war. It would be impracticable to visualize successful individual services without active methods of prevention and the maintenance of community health by competent health departments. It would be folly to pretend that atomic attacks would not devastate wide areas and could leave desolation where material, beauty, and human production once were evident. It would be futile to evade the fact that this bomb would kill, maim, and warp persons not fortunate enough to protect themselves adequately.

Explosion Hazards

The public has a right to and needs to know that the atomic bomb produces most of its damage, by far, exactly like previously known bombs. The two exceptions, and only two, are that the magnitude of the atomic bomb damage is far greater and that, to a limited degree, there is an added radiation effect. What the public will believe, as soon as their physicians and health departments tell them at every opportunity, is that valuable and available measures favor the survival of most of those resisting attack. Some of the measures will be precautionary, some restorative to meet the three hazards of blast, heat, and radiation. None of these three differs qualitatively from the same

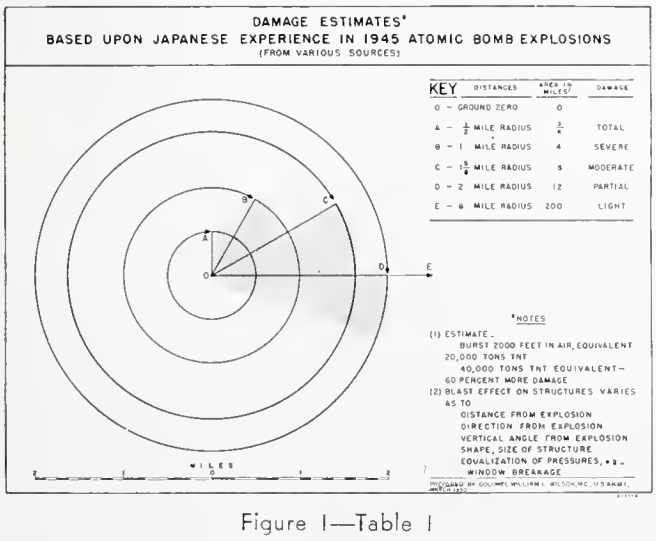


Figure 1—Table 1

hazards faced frequently by people who are not exposed to atomic bombing. Physicians and related health personnel already know these hazards. In addition, no one has as great access to individuals and families as physicians. They should, therefore, earn the full public confidence in advice and leadership in matters pertaining to their health under atomic attacks. Let us enlarge a bit upon some facts.

The bomb is likely to explode in the air, but could land on the ground or in water. If it should explode in the air, the material damage would be similar to that listed in table 1,[1] presented diagrammatically in figure 1. The number of people surviving will increase from the center outwards. The fewest survivors will be found within one-half mile of the burst until we may have maximum and extensive precautionary measures not generally foreseeable. Casualties requiring medical services will be found mostly in a middle zone, neither centrally nor peripherally. The casualties would be produced in a manner indicated in table 2; if Japanese experience were applicable, 65 per cent would be due to blast, 20 per cent due to heat, and no more than 15 per cent due to all forms of radiation; perhaps only 1 per cent would be delayed radiation, most radiation hazard coming with the "flash." The medical nature of total casualties from one bomb has been well publicized,[2,3] and variously estimated at perhaps 50,000 for an average American target area.

Public Responsibility

Three large groups of public responsibility exist for meeting these explosion hazards:

The first responsibilities, belonging to individuals, may be learned from table 3.

The second, belonging to medical and health services, constitute the subject of this paper.

The third group, belonging to local, state, and national governments, constitute the necessary organizing, administering, and supporting by logistic and other measures, of the efforts of individuals and all groups.

Individuals can meet their responsibilities only after we learn everything they need to know, then teach them. We must revise and add to these teachings whenever new knowledge is developed. In the other direction we must develop our medical plans at the same time we advise and aid in every practicable way the governmental efforts.

Medical plans for atomic warfare can be made relatively simple.[4] Although there has been no fundamental change in the character of any of the essential medical services necessitated by atomic bombs, their management and implementation will require long and careful training of all participants. It should be comforting to

know that a system which was adequate ten years ago" will be just as satisfactory now if we provide for the greater magnitudes and the new problems of radiation. Plans will be required for three fields of health services, all integrated unto a uniform system:

AIR BURSTS OF ATOMIC BOMB

	PERCENT OF CASUALTIES	WHAT HAPPENS	INCIDENCE
BLAST	65	1 POSITIVE PHASE A PUSH OUT	PRESSURE OUT FROM BURST USUALLY NOT ENOUGH TO KILL. FLYING DEBRIS CAUSED ALMOST ALL INJURIES
		2 NEGATIVE PHASE A SUCK IN	HIGH WINDS UP TO 100 MPH BLOWS TOWARD CENTER OF BURST & UP INTO CLOUD
HEAT	20	1 "FLASH" HEAT	FLASH AT THE TIME OF BURST BURNS OCCUR OUT TO TWO MILES EASILY PROTECTED BY LIGHT CLOTHES OR ANY SHIELDING SUBSTANCE
		2 SECONDARY FIRES	STARTED BY STOVES, SHORT CIRCUITS AND THE LIKE. CUT-OFF OF UTILITIES WILL PREVENT THESE FIRES
RADIATION	15	1 "FLASH" RADIATION GAMMA NEUTRON	CANNOT SEE HEAR OR FEEL IT, BUT IT IS THERE FOR A FLASH. GAMMA RAYS ARE MOST PENETRATING AND LONGEST RANGE MORE MATERIAL BETWEEN YOU AND BLAST PROTECTS YOU MORE GAMMA DECREASES AS THE SQUARE OF THE DISTANCE FROM BURST
		2 LINGERING RADIATION ALPHA BETA	SO SMALL, IT IS NOT A HAZARD DISREGARD IT

Table 2

	WHAT TO DO
1 DISPERSE	IF WARNING IS GIVEN GET AWAY FROM POSSIBLE TARGET AREA AND AREAS THAT ARE BUILT UP REMEMBER THE FLYING DEBRIS
2 TAKE COVER AND STAY FOR ABOUT 90 SECONDS	BASEMENTS, UNDERGROUND SHELTERS IF POSSIBLE GET CLOSE TO BASEMENT WALLS AND NEAR GOOD EXITS FROM BASEMENT AFTER BURST REMEMBER GET THE MOST MATERIAL BETWEEN YOU AND THE BURST
3 HELP OTHERS	THOUSANDS OF LIVES CAN BE SAVED BY PROMPT AID HELP SAVE LIVES BY HELPING OTHERS 90 SECONDS AFTER BURST THE DEBRIS HAS STOPPED FALLING AND THERE IS NO RADIATION HAZARD
4 REPORT TO DESIGNATED PLACE	ORGANIZATION IS NECESSARY TO REDUCE THE EFFECTS OF THE BOMB REPORT TO RECEIVE TREATMENT IF NECESSARY, BE EVACUATED IF DESIRABLE AND TO WORK TO HELP OVERALL SITUATION
5 DON'T EAT CHEW DRINK OR SMOKE UNTIL ITEMS ARE CHECKED & CLEARED	A SMALL AMOUNT OF RADIATION OUTSIDE THE BODY IS HARMLESS INSIDE THE BODY IT MAY CAUSE MUCH TROUBLE KEEP IT OUTSIDE
6 DON'T SPREAD RUMORS	THINGS WILL BE TOUGH ALL OVER KEEP YOUR EXPERIENCE TO YOURSELF AND DON'T EXAGGERATE ON WHAT YOU HEAR FROM OTHERS
7 SCRUB DOWN & CHANGE CLOTHES	AS SOON AS PRACTICABLE SCRUB DOWN AND CHANGE CLOTHES SCRUB HAIR FACE, HANDS AND FINGERNAILS WELL

Table 3

Medical and health services of truly essential nature required by communities with or without enemy attack.

Casualties services constituting medical care and therapy made necessary solely by enemy attack.

Public health services made additionally necessary solely by enemy attack.

In the matter of essential continuous services, additional concentration upon measures directed toward preventive medicine, particularly sanitation, hygiene, epidemiology, and immunology, as well as towards increasing mental hygiene, will aid materially in meeting potential biologic hazards as well as psychologic warfare. It must be obvious that these would accompany or follow atomic explosions.

Any medical planning required for atomic warfare should be concentrated upon the administrative aspects, without which it would be impossible to apply economically and efficiently the available technical plans and knowledge pertaining to the subject. There should be plans for the casualties and public health services made necessary solely by enemy attacks. To repeat, this would be largely an administrative problem and must be directed at provisions for personnel, equipment and supplies, transport means, plant facilities, operational schemes, management, and their integration with other equally essential activities of nonmedical nature.

The treatments required by individual casualties surviving atomic explosion differ in no manner whatever from the best known treatments administered to patients currently by American physicians. Except for the vastly increased numbers, the medical profession has no newer or greater problem in treating atomic casualties than is faced daily in efforts to improve the quality of all technics. The medical planning, therefore, must be directed towards treatment of thousands of patients suffering from blast, heat, and radiation.

Preventive Measures

We should digress at this point long enough to stress the enormous advantages of properly taught preventive measures. The public, the medical and health services, suppliers of material, industrial production, and prosecution of a war effort all depend upon success along this line. Known countermeasures to blast, heat, and radiation due to other causes than atomic explosion can be applied successfully, even if proportionately only, to minimize the personal effects of atomic explosion. We will never need to treat the casualty which was avoided by one's own efforts. If not avoided, we must treat each one. Our objective then must be diminishing numbers of casualties brought about by application of preventive medicine.

Medical experience must be applied to obtain intelligent avoidance of blast injury, limited at present to Japanese experience along a potential distribution of 50 to 60 per cent contusions, 30 to 40 per cent lacerations, and 7 to 15 per cent fractures. It is essential that we be prepared to revise our estimates as new experience dictates. What each person can do has been discussed by Gerstell[6] in a recent popular article of real merit. The preferred procedure is orderly movement out of the target area; when impracticable to do that, the next best choice is the deepest and closest available foxhole, well covered over, of a type permitting

THE INFLUENCE OF DOSE-RATE
ON BIOLOGICAL EFFECT FOR EXTERNAL WHOLE BODY RADIATION
(FROM UNCLASSIFIED MATERIAL PROVIDED BY THE ARMED FORCES SPECIAL WEAPONS PROJECT)

DURATION OF EXPOSURE	50r ACCUMULATION	100 TO 300r ACCUMULATION	400r ACCUMULATION	500r ACCUMULATION
ONE MINUTE	LOWEST DOSE THAT WILL GIVE DETECTABLE EFFECT (DROP IN WHITE BLOOD CELL COUNT) THE PATIENT FEELS NOTHING (1)	AT 100r THE FIRST SYMPTONS APPEAR 300r WILL INCAPACITATE A MAN FOR ABOUT SIX MONTHS 200r – HOSPITAL PATIENT (1)	THE 50% LETHAL DOSE – 1/2 OF ALL PERSONS RECEIVING THIS DOSE WILL DIE. (2)	100% LETHAL DOSE (2)
24 HOURS	EFFECT REDUCED BY 50% – ONLY 1/2 WILL SHOW DROP IN WHITE BLOOD CELL COUNT (3)	EFFECT REDUCED BY 25% FROM ONE MINUTE EXPOSURE (3)	EFFECT REDUCED BY 50% FROM ONE MINUTE EXPOSURE (3)	EFFECT REDUCED BY 50% FROM ONE MINUTE EXPOSURE. (3)
30 DAYS	NO DETECTABLE EFFECT (4)	SLIGHT BLOOD CHANGES NO SYMPTOMS (4)	SLIGHT BLOOD CHANGES NO SYMPTOMS (4)	DEFINITE BLOOD CHANGES MILD NAUSEA (4)

r - MEANS ROENTGENS
1. WELL ESTABLISHED BY RESULTS ON HUMANS
2 RELIABLE EXTRAPOLATIONS FROM ANIMAL EXPERIMENTS
3 LESS CERTAIN EXTRAPOLATIONS FROM ANIMAL EXPERIMENTS.
4 ESTIMATES

Table 4

later easy exit. The need for dispersion and distance can be applied to hazards of heat and radiation, as well as blast.

If sufficient cover against radiation is achieved, it will likely protect also from the blast and heat effects of an explosion. The greatest radiation hazard will be the gamma rays because of their large quantities and long range at the "flash" or explosion of the bomb. While 1 inch of steel, 3 inches of concrete, or 4 inches of wood or earth will reduce the gamma intensity to half its initial amount,[7] we must stress the enormous quantity which must be avoided or dissipated. It has already been indicated that other radiation hazards may be disregarded in the period immediately following explosion, at least until lingering or residual presence can be identified and measured by monitors. Although not universally agreed, the maximum daily allowable exposure to radiation has been set at 0.1 roentgen (or 0.1r—the quantity of X-radiation which on passing through 1 cc. of normal air produces 1 electrostatic unit of ions).[2] Table 4 demonstrates the influence of dose-rates on biologic effects from whole body radiation.

Treatment

It must be stressed that survivors of a blast who require treatment will need far more immediate attention to their lacerations and fractures and to a lesser degree their contusions than for radiation. The treatment technics are well established for these.

The greatest treatment problems likely would result from the large numbers and severe types of burns, particularly the "flash" burns in the event victims failed or were unable to take cover.[2] Almost all who need treatment will have

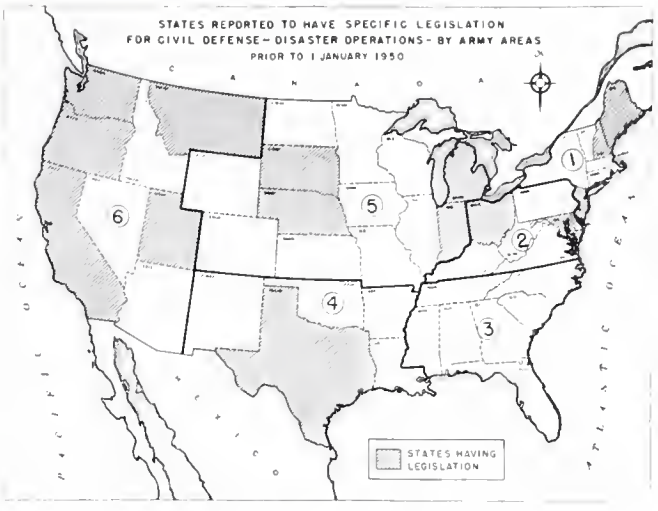


Figure 2

burns. It is unnecessary to determine whether the burns are of "flash" or secondary flame origin as the pathology and treatment likely would be similar for all burns of equal degree. Of particular importance will be the rapid initial treatment, evacuation, and early definitive care for prevention of complications such as shock and infection. Technics and improved methods for handling these cases have been reported to be under careful and extensive study.

The treatments for radiation injuries, though relatively fewer than the others, may be complicated by the fact that in many such cases there will be burns also, the treatment for which may conflict with that for radiation.[2] We must await research successes to report the best general treatments in these cases.

The large quantities of dressings, antibiotics, blood, or blood derivatives and substitutes re-

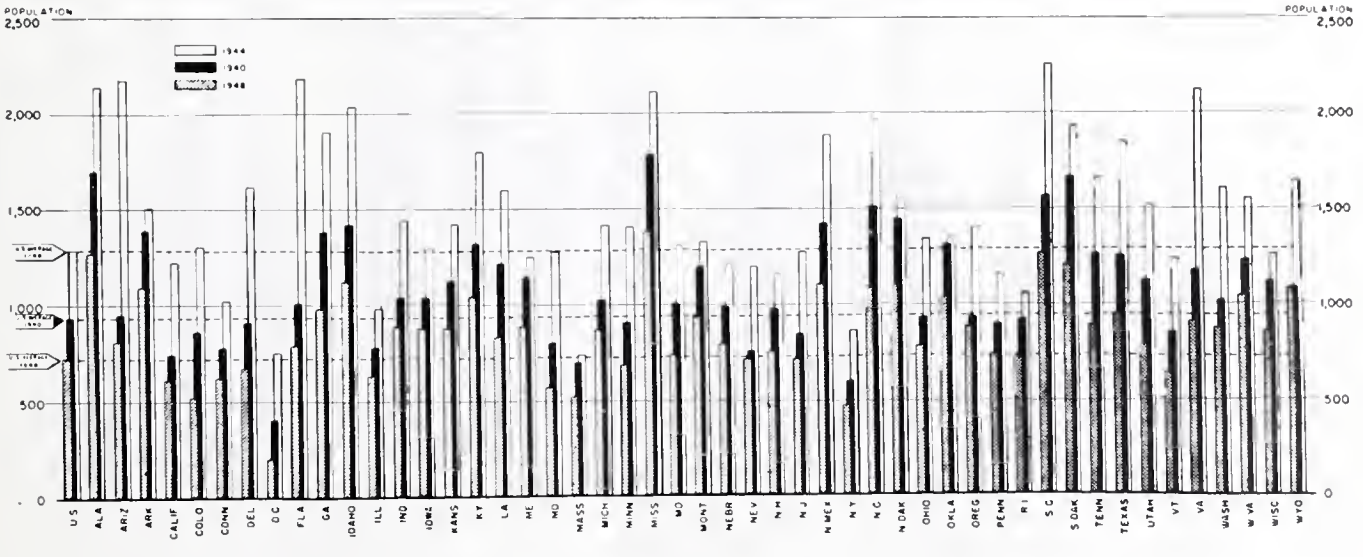


Figure 3

quired for thermal and radiation casualties cannot be stressed too much. The pathology involved[2 3 8 9] and treatments attempted to date are discussed in available pertinent publications.[2 3]

Community and State Plans

In view of the large volume of services required, special medical plans for every community will be necessary. Although they have been recorded elsewhere,[4 10] the details deserve review at this time with a view to uniformity. Every community must do all it can for itself prior to receiving support and aid from others. Until every community has made its own plans and can be ready for its own problems, it would be unable to send support or aid to others with economy and efficiency. All of us may hope that every community likely to be called upon to render support to others, as well as every community likely to be a target of enemy attack, and every state, would do all possible to minimize the effects of atomic warfare. We should all see that the following are done by communities and states:

Plans are made and published

Available means are marshalled

Additional measures are undertaken, in the order listed:

- Fixing responsibilities for activities involved
- Establishing full authority for meeting each responsibility.
- Indexing responsibilities and authorities, divided into those currently existing and those not existing but required
- Obtaining additional legislation or administrative acts required for (fig. 2):
  - Fixing responsibility
  - Prescribing authority
  - Providing means
- Providing means by:
  - Survey of available resources
  - Determination of requirements of essential needs
  - Allocations of means to needs from available resources
- Setting up a proper administration for:
  - Preparation and maintenance of plans
  - Budgeting, procurement, and disbursement of funds
  - Establishment of policies, procedures,

RATIO OF POPULATION TO ONE PHYSICIAN
UNITED STATES—BY CENSUS AREAS AND REGIONS*

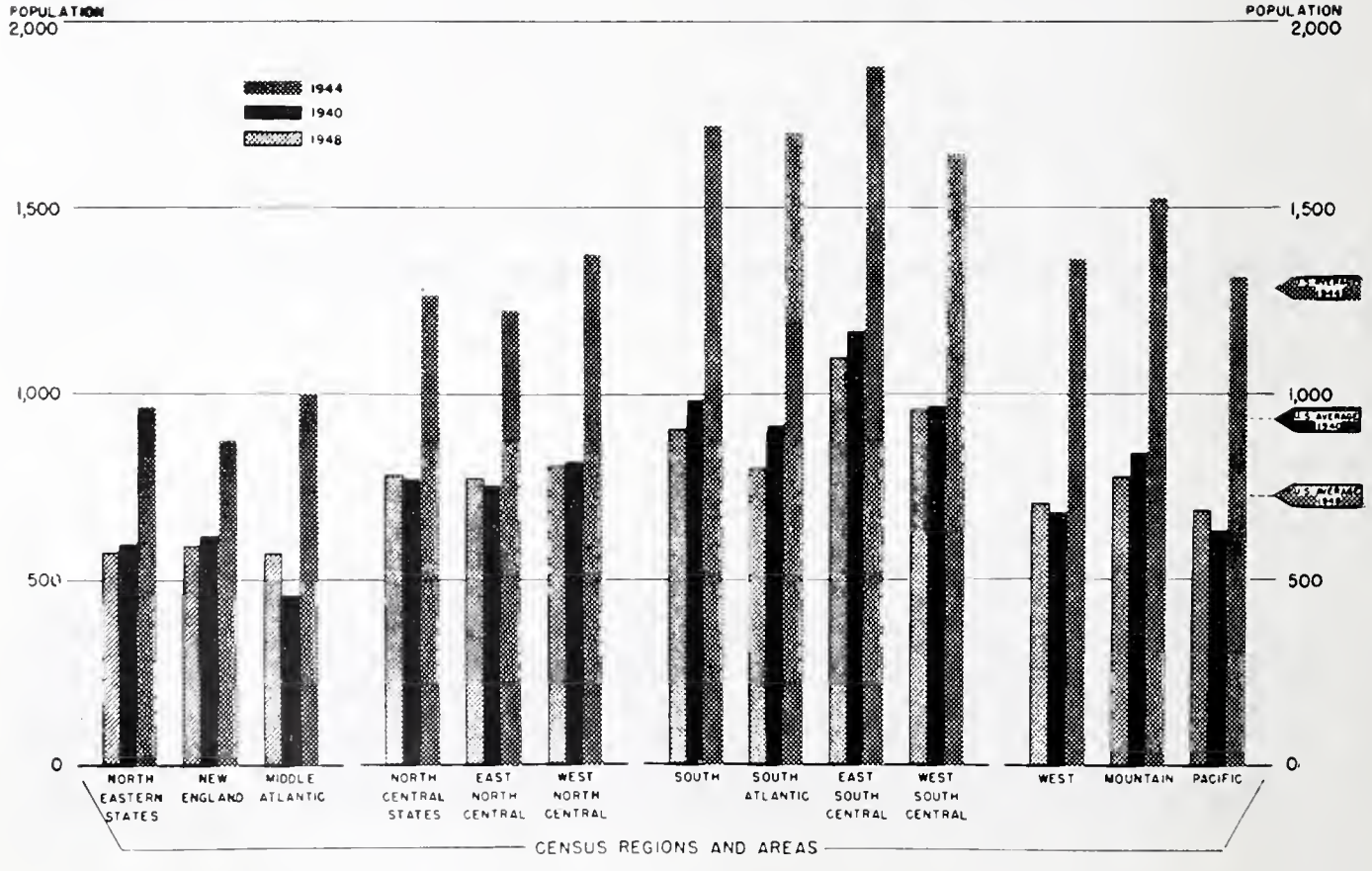


Figure 4

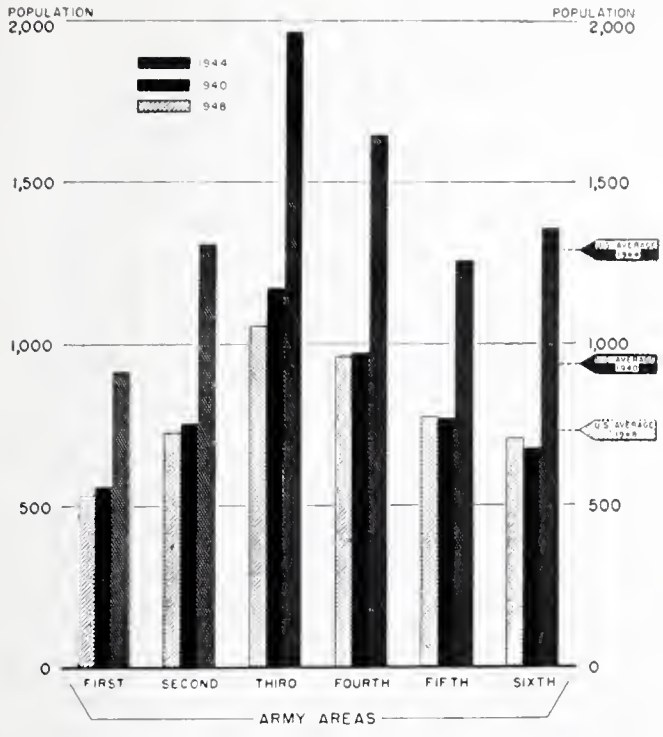


Figure 5

training programs and guides, and operational systems

Activation of functional units

Procurement of personnel

Organization and training of units and individuals

Standardization for procurement, storage, issue and maintenance of physical means; plant facilities; equipment and supplies; transport

Establishing an adequate records and reporting system

Integrating civil and military plans and operations which can be assured by:

A simple classification of the adult population, so that we could assign all immediately to essential duties in emergencies[11]

Development of standards of the minimum of health services that could be made to suffice during the emergency

POTENTIAL SITUATIONS REQUIRING *(INTERIM)* MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

COMMUNITY OR PLACE OF DISASTER OR EVENT	COMMUNITY TO FURNISH INITIAL RELIEF HEALTH SERVICES	COMMUNITY REQUIRING SERVICES	SOURCE FOR ADDITIONAL HEALTH SERVICES WHEN OWN OVERWHELMED	COMMUNITY TO FURNISH TEAMS FOR SERVICES	COMMUNITY IN WHICH SERVICES MAY NEED TO BE PROVIDED
OWN ONLY	OWN	OWN ONLY	OWN EXPANDED OWN IMPROVISED ANOTHER COMMUNITY	OWN OWN OWN + OTHERS	OWN OWN OWN + OTHERS
ANOTHER ONLY	OTHER	OTHER ONLY	OTHER EXPANDED OTHER IMPROVISED OTHER + OURS	OTHER OTHER OTHER + OURS	OTHER OTHER + OWN OTHER + OWN
OWN & ANOTHER	OWN + OTHER	OWN + OTHER	OWN + OTHER EXPANDED OWN + OTHER IMPROVISED OWN + ALL OTHERS	OWN + OTHER OWN + OTHER OWN + ALL OTHERS	OWN + OTHER OWN + OTHER OWN + ALL OTHERS

Table 5

Inventory of all civilian health resources

Obtaining uniformity in classification of health personnel and in their organization into units of a type which would be equally adjustable to civil or military administration in wartime; could be transferred from one control to another with facility, and could be utilized with economy and efficiency by either

Indexing our aggregate medical and health resources (figs. 3-5)

Only by this means can we distribute our resources equitably and rapidly.

In addition to matters just mentioned, when requested to do so, military advisors should, as authorized, concentrate upon certain details of major importance to civilians undertaking civilian defense planning.[4] The former may advise upon and stimulate the following:

The planning and establishment of simple civilian operational systems to include considerations of potential situations requiring (interim) medical plans for civil defense and disaster (table 5), possible situations (table 6), resources available (table 7), and those required to be preplanned and allocated (table 8); the services required (table 9), as well as special management problems (table 10); the zones of possible activity (table 11); we may aid in an inventory of personnel (table 12), as well as hospital beds (table 13), medical supplies (table 14), and medical transport (table 15); and we should help set up a local hospital plan (fig. 6), a local system of hospital evacuation for convalescent patients (fig. 7), and an evacuation scheme for all casualties (fig. 8).

Assurance that we obtain the necessary knowledge and administration to provide adequate nutrition under generalized disaster conditions in industry and in our public food planning for war.[12]

Maximum knowledge as to damage to be expected from atomic explosions (fig. 1).

Maximum attention to available references on the medical aspects of atomic weapons.

Maximum attention to possible defenses against psychologic,[12] biologic,[13 14] and chemical warfare.

Regular review of plans and revision of plans and systems as populations move, cities develop, employment changes, and other changes occur.

Attention to sanitation,[5 15] and the teaching of hygiene to all citizens. No single effort is likely to result in the greatest possible returns of civilian health so much as a population well informed in personal and community hygiene.

Preparation for handling of medical and

other health problems related to migrations,[16] evacuations[17], and resettlements or relocations.[18]

Repeating somewhat, insistence that every community, every hospital and school, every industrial or utility and service plant, every industry or corporation, and every state has:

Adopted a simple plan which is feasible, is understandable by all, and is adaptable to all other community, state, and national plans.[5]

Made sure that every possible participant understands his part and obligation under the plan.[19]

Limited every plan to resources, means, and operational possibilities likely to exist at the time of disaster.

Tested plans regularly by exercises and drills.

Summary

In summary, we have shown how medical plans for atomic disaster will benefit the nation; what the hazards would be; how individuals, communities, professions and governments all have positive responsibilities and capabilities for minimizing the effects of atomic explosion. Without underestimating the hazards, we have shown that the effects of atomic explosion can be minimized.

In brief, we have reviewed what happens,

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED
a CATEGORY OF EMPLOYMENT OF RESOURCES

CASUALTIES SERVICES	PREVENTIVE AND PUBLIC HEALTH SERVICES
MEDICAL CARE AND THERAPY MADE NECESSARY SOLELY BY ENEMY ATTACK OR DISASTER	MADE NECESSARY SOLELY BY ENEMY ATTACK OR DISASTER
SOME QUALITATIVE INCREASE OF NORMAL SERVICES, BUT PRIMARILY MASS TREATMENT INSTEAD OF INDIVIDUAL TREATMENT MUST BE ORGANIZED	PRIMARILY QUANTITATIVE INCREASE OF NORMAL SERVICES, BUT MORE VIGILANCE, SPEED, IMPROVISATION, MOBILITY, SUSTAINED EFFORT, COURAGE — REQUIRED
	COMPLETELY ORGANIZED EPIDEMIOLOGICAL SERVICE

Table 6

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED
b CATEGORY OF SERVICES REQUIRED
(UNITS & TEAMS TO BE ORGANIZED)

TREATMENT OF WOUNDS	TREATMENT OF CHEMICAL CASUALTIES
ROUTINE - CLEANSING, ANTISEPSIS, ANTIBIOTICS, ANESTHESIA, ANALGESIA	TREATMENT OF RADIOLOGICAL CASUALTIES
SHOCK - RESUSCITATION, MEDICATION, BLOOD OR BLOOD DERIVATIVES - OTHERS	TREATMENT OF NEURO-PSYCHIATRIC CASUALTIES
HEMORRHAGE - BLOOD & DERIVATIVES	PREVENTIVE & THERAPEUTIC HANDLING OF CONTAMINATIONS & CONTAMINATED PERSONS WHETHER CASUALTIES OR NOT RADIOLOGICAL, BACTERIAL & VIRAL, CHEMICAL*
INFECTIONS - PROPHYLAXIS - DEFINITE TREATMENT	
FLESH WOUNDS - IMMOBILIZATION, HEMOSTASIS, SUTURE - OTHERS	EVACUATION - FIRST AID, AID STATION LITTER SQUADS
BURNS - PHYSICAL, CHEMICAL, RADIOLOGICAL, *(FLASH)* - MASS TREATMENT	AMBULANCE - DRIVERS, ATTENDANTS
VASCULAR INJURIES - HEMOSTASIS, SUTURE, REPAIR	
NERVE	
BONE - JOINT	
ABDOMINAL - PELVIC	
CHEST - LUNG	
HEAD	
MAXILLO-FACIAL-ORBITAL	

INJURIES REQUIRING SPECIALIST TEAMS

Table 9

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(1) CATEGORY OF RESOURCES
REQUIRED BY CIVIL DEFENSE AND DISASTER HEALTH SERVICES
(EXCESS TO USUAL, NORMAL REQUIREMENTS)

- HOSPITAL FACILITIES
- CONVALESCENT FACILITIES
- PERSONNEL
- TRANSPORT
- MEDICAL SUPPLIES
- BLOOD - BLOOD DERIVATIVES
- MEDICAL EQUIPMENT
- FOOD
  CLOTHING
  FEEDING SANITATION
  HYGIENE
  INSECT/RODENT CONTROLS
  OTHER NON-MEDICAL EQUIPMENT AND SUPPLIES
- MEDICAL ADMINISTRATION MANAGEMENT FOR - DISASTER OR INCIDENT PERIOD

Table 7

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED
c CATEGORY OF SPECIAL MANAGEMENT
(FOR RESPONSE IN DISASTER OR ENEMY ATTACK)

HOSPITALS	ALLOCATION OF EQUIPMENT & SUPPLIES
PREVENTIVE & PUBLIC HEALTH SERVICES	PROCUREMENT, STORAGE, MAINTENANCE ISSUE AND DISTRIBUTION OF EQUIPMENT AND SUPPLIES
RECORDS & REPORTING SYSTEM *(SPECIAL CASUALTY REPORTING)*	PROVISION OF MEDICAL TRANSPORT
MEDICAL REGULATING SERVICE	CONTROL OF FLOW *(REGULATING SERVICE)*
CONTROL OF PATIENT FLOW	AMBULANCE VEHICLES
UNIT *(TEAM)* ORGANIZATION, TRAINING, EQUIPMENT, TESTING	SUPPLY VEHICLES
ALLOCATION & ASSIGNMENT OF UNITS AND INDIVIDUALS TO	PROVISION OF BLOOD & DERIVATIVES
AT HOME: GEOGRAPHIC AREA OF CITY; TYPE OF SERVICE TO PERFORM; PLACE OF DUTY - EXACT PLACE OFFICE CONTROLLING THEM; PERIODS OF DUTY	MASS HEALTH SERVICES - PREVENTIVE MEASURES, PARTICULARLY IN MASS EVACUATIONS, MIGRATIONS, WAR-DISPLACEMENTS
AWAY - SUPPORT OTHER COMMUNITIES *(AS ABOVE)*	

Table 10

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(1) CATEGORY OF RESOURCES
REQUIRED BY CIVIL DEFENSE AND DISASTER HEALTH SERVICES
(EXCESS TO USUAL, NORMAL REQUIREMENTS)

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED
a CATEGORY OF EMPLOYMENT OF RESOURCES
b CATEGORY OF SERVICES REQUIRED
(UNITS & TEAMS TO BE ORGANIZED)
c CATEGORY OF SPECIAL MANAGEMENT
(FOR RESPONSE IN DISASTER OR ENEMY ATTACK)
d ZONE OF ACTIVITY
(FROM CENTER OUTWARDS - EVEN BEYOND CITY LIMITS)

Table 8

PRELIMINARY ESTIMATE OF SITUATION
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

(2) RESOURCES REQUIRED TO BE PREPLANNED AND ALLOCATED
d ZONE OF ACTIVITY
(FROM CENTER OUTWARDS - EVEN BEYOND CITY LIMITS)

INCIDENT, COLLECTING	INITIAL SELF-AID, FIRST AID	
EVACUATION	LITTER SQUAD, COLLECTING-AID-POST	
	AMBULANCE	
HOSPITAL	SECONDARY *(CLEARING)* HOSPITAL	
	BASE *(GENERAL)* HOSPITAL	
CONVALESCENT		CONVALESCENT HOSPITALS, HOMES
MUTUAL SUPPORT		RED CROSS, OTHER COMMUNITIES, OTHER STATES, ARMED SERVICES, OTHER

Table 11

what to do, and in a limited degree how to do it. Each citizen becomes a key performer and the extent to which each practices the preventive medicine we shall teach him for casualty avoidance will be a measure of his patriotic duty—a responsibility he has to himself, his community and his nation. Only the future can reveal the extent of catastrophe likely to result when people make no effort to save themselves. It has been characteristic of our medical profession, however, to accept no defeats, to know no fears, to withhold no service to victims of disaster.

SAMPLE INVENTORY OF PERSONNEL
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

MEDICAL PERSONNEL	IN PUBLIC HEALTH SERVICES	IN SCHOOL FACULTIES	UNAVAILABLE IN ARMED SERVICES RESERVES	AVAILABLE (LESS SPECIALISTS) (A) BY ZONE OF CITY (C) NW	NE	SE	SW	NOTES
PHYSICIANS (A)								(A) DOES NOT INCLUDE SPECIALISTS CERTIFIED BY AMERICAN BOARDS THESE SHOULD BE LISTED SEPARATELY BY BOARD SPECIALTY AND BY SAME CATEGORIES AS SHOWN FOR PHYSICIANS TO PERMIT ALLOCATIONS TO DUTIES
DENTISTS								
NURSES-GRADUATE								
PHARMACISTS								
VETERINARIANS								
SANITARIANS								
DIETICIANS								
PHYSICAL THERAPISTS								
NURSES' AIDES								
PRACTICAL NURSES								
TRAINED ORDERLIES								
LABORATORY TECHNICIANS								
X-RAY TECHNICIANS								
OTHER TECHNICIANS (B)								(B) INCLUDES— DENTAL LABORATORY DENTAL DENTAL HYGIENIST MEAT & DAIRY INSPECTION PHARMACY MEDICAL EQUIPMENT & MAINTENANCE VETERINARY ORTHOPEDIC MECHANIC OPTICIAN SURGERY ALL OTHER TECHNICIANS & TECHNICALLY TRAINED AIDES
UNTRAINED ORDERLIES								
LABORERS								
NON-MEDICAL BUT ESSENTIAL PERSONNEL								
ADMINISTRATIVE								
HOUSEKEEPING								
ENGINEERING								
UTILITIES								
SERVICES								(C) WHERE EACH IS MAJOR PART OF EVERY DAY

Table 12

The most critical test of our medical plans then will be the extent to which we shall attain all-around cooperation, performance by medical and health services under key staff members, but above all, our success or failure in maximum development and quality of the medical leadership available. With reasonable success in all of these, at least equal to that of the past, there could be nothing but triumph if we should ultimately be put to a critical test. If we should plan our future fully and never put the plans to test, there could be nothing but universal gratification.

SAMPLE CITY
HOSPITAL BEDS FOR DISASTERS
IMMEDIATELY AVAILABLE

DTR OF CITY	HOSPITAL: BASE (FULL SURGERY)	HOSPITAL: SECONDARY (CLEARING)	HOSPITAL: ADDRESS (STREETS & NUMBERS)	NUMBER OF BEDS IN HOSPITALS—WITH ADEQUATE SPACE: TOTAL WITH EMERGENCY BEDS	IN REGULAR DAILY USE	NOT IN REGULAR USE BUT READY FOR EMERGENCY: IN HOSPITAL	ELSEWHERE	SOURCE OF EMERGENCY BEDS: FROM HOSPITAL STORES	OUTSIDE (LIST SOURCE)	NUMBER OF BEDS IN IMPROVISED HOSPITALS: NORMAL USE OF SPACE	SOURCE OF BEDS
	CITY	—		1200	900	200	100	200	100		
		DOAKS	8TH & MAIN	175	165	10	—	10	—		
		MERCY	1923 GRAND ST	150	150	—	—	—	—		
NW	ST THOMAS	—	LEE & FRONT	975	900	50	25	50	25		
		CHARITY	15 HIGH ST	200	175	20	5	20	5		
		J ACADEMY	HIGH & FRONT	—	—	—	—	—	—		
		T WHSE	UNION SQUARE	—	—	—	—	—	—		
3150	(2)	(5)		2700	2290	280	130	280	130	450	
NE	WESLEY	—		450	450	—	—	—	—		
		NONE	22-5 MAIN	—	—	—	—	—	—		
450	(1)	—		450	450	—	—	—	—		
SE	NONE	—									
		NONE									
—	—	—									
SW	MATERNITY	—		75	70	5	—	5	—		
		UNIV	ELM & PEARL	—	—	—	—	—	—	NORM 700	UNIV
775	(1)	(1)		75	70	5	—	5	—	700	
TOTAL 4375	(4)	(6)		3225	2810	285	130	285	130	1150	

Table 13

SAMPLE INVENTORY OF MEDICAL SUPPLIES
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

LISTING BY ITEM REQUIRED	AVAILABLE AT ALL TIMES IN CITY	REQUIRED BY ZONE OF CITY NW	NE	SE	SW	SHORTAGES BY ZONE OF CITY NW	NE	SE	SW	SOURCES FOR MAKING UP SHORTAGES	TIME REQUIRED TO PROVIDE FOR SHORTAGES
BLOOD & DERIVATIVES											
DRUGS, BIOLOGICALS, PHARMACEUTICALS, ANTIBIOTICS											
SURGICAL DRESSINGS BANDAGES											
SURGICAL INSTRUMENTS, INSTRUMENT SETS, AID KITS											
SHOCK TEAM EQUIPMENT											
LABORATORY SUPPLIES											
DENTAL SUPPLIES *(EMERGENCY)*											
X-RAY SUPPLIES											
MISCELLANEOUS HOSPITAL AND MEDICAL SUPPLIES											
SANITATION SUPPLIES											
OTHERS											

Table 14

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SAMPLE INVENTORY OF MEDICAL TRANSPORT
(INTERIM)
MEDICAL PLANS FOR CIVIL DEFENSE AND DISASTER

VEHICLES FOR MOVEMENT OF PATIENTS AND MEDICAL MATERIAL		NUMBER AVAILABLE AT ALL TIMES IN CITY	NUMBER REQUIRED BY ZONE OF CITY NW	NE	SE	SW	SHORTAGES TO BE MADE UP BY ZONE OF CITY NW	NE	SE	SW
TYPE OF VEHICLE										
MOTOR AMBULANCE										
MOTOR TRUCK	VANS									
	LARGE CARGO									
	SMALL CARGO									
MOTOR BUS										
OTHER VEHICLES										
LITTERS										
BLANKETS										
SPLINTS AND VEHICLE AID KITS										

Table 15

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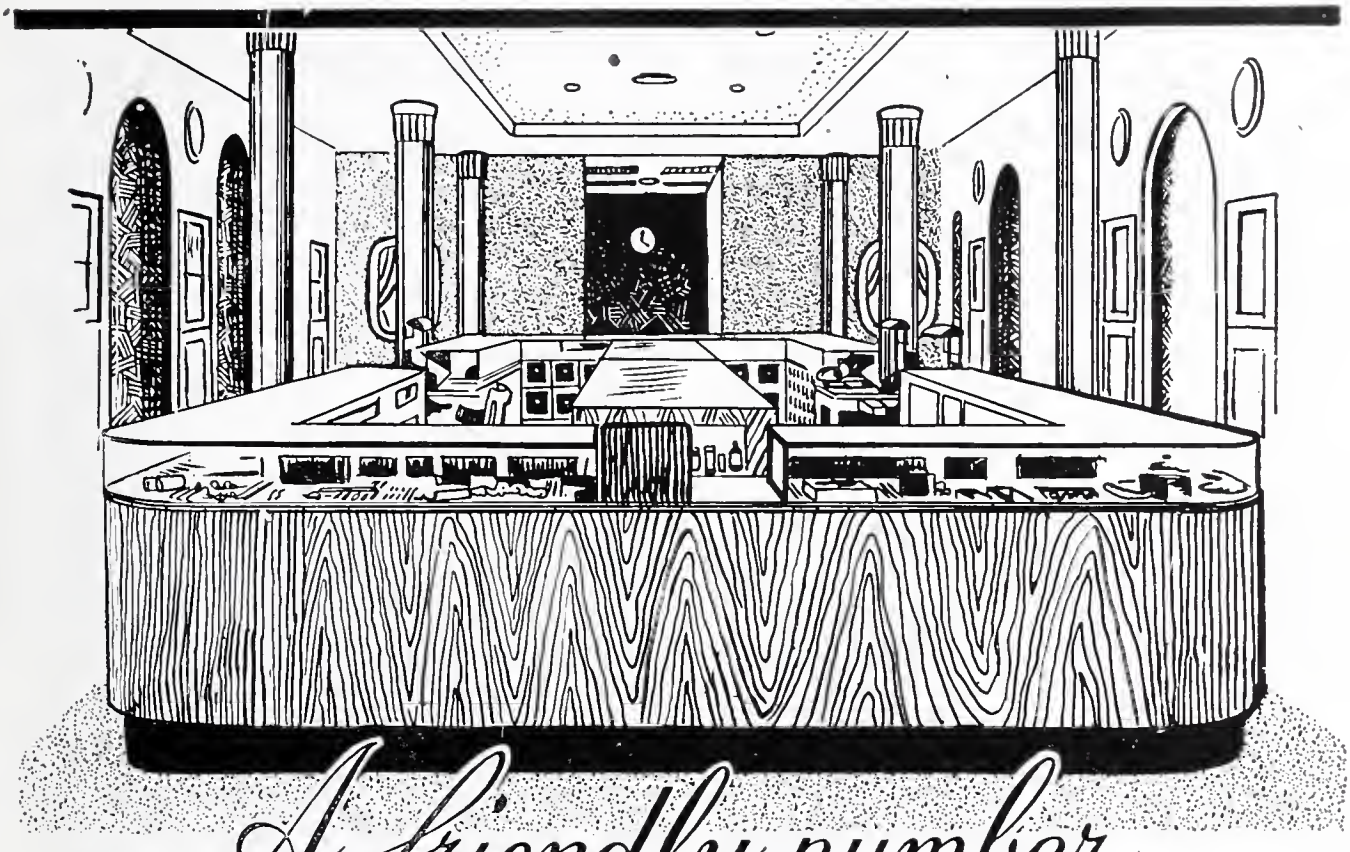
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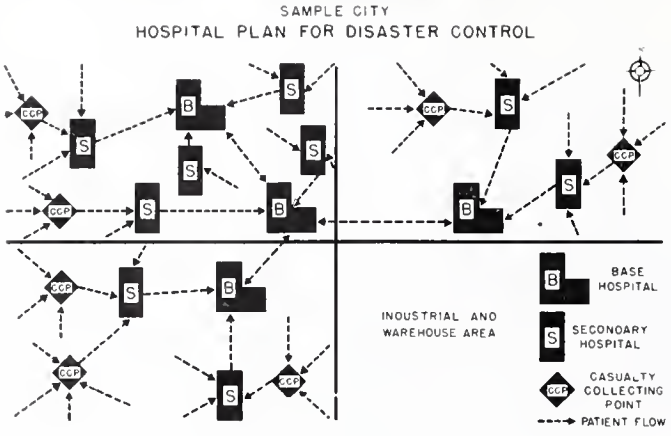


Figure 6

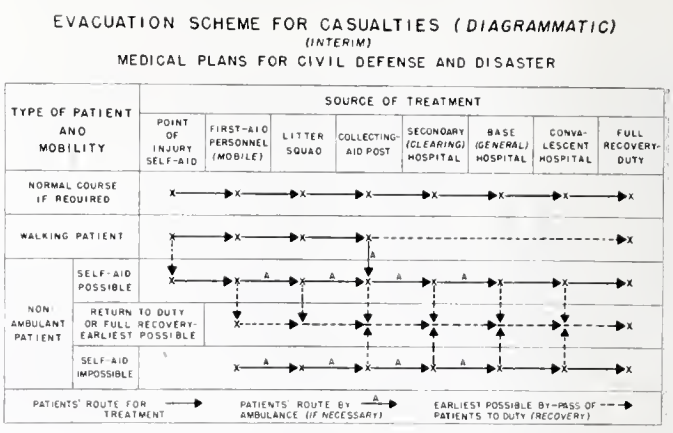


Figure 8

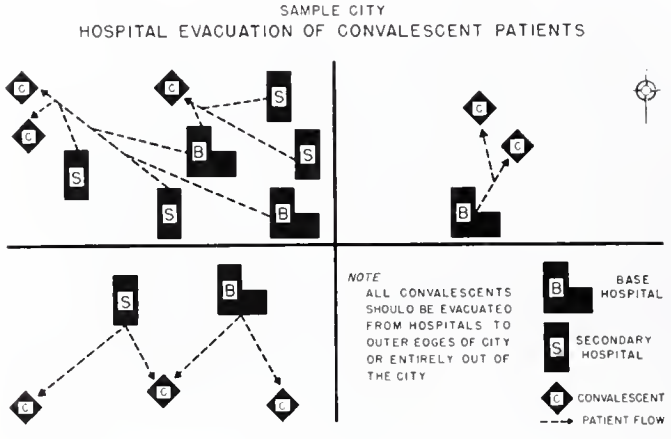


Figure 7

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EDITORIAL

PUBLIC RELATIONS CONFERENCE

Fount Richardson, M.D.
Fayetteville

In many ways, the Public Relations Conference held by the A.M.A. in Cleveland, December 3 and 4, was successful. Some speakers roundly criticized the "Ivory Towers" of the A.M.A. for the lackadaisical conduct of the campaign against the socialization of America. Somewhere in the smoke-filled hotel rooms, the indignation of physicians everywhere needled the College of Surgeons to stand on their hind legs and fight like a man. It was announced later that they had reconsidered and would retain the standardization of hospitals as a function of that organization. Perhaps it was because the Academy of General Practice had said that if no one else would do it, that the GP's would.

County Medical Society speakers from Toledo, Columbus, Milwaukee, Tulsa, and other places, drove home the fact that the public relations isn't a headquarters job, that it is a job to be done in the county; even in the doctor's office, where bulletins, clever posters, simple friendly personal meeting of the patient; stressing the idea of the family doctor, were among the things recommended. The "Toledo" plan seemed most valuable for cities of the larger type. A grievance committee worked with this plan and many people who were overcharged or thought they were overcharged were given hearings. The doctors who were offenders were pointed out. It did some good there.

Basically, the idea went over that the physician can do more to fight socialism than anyone else, and in his own office, among the people he meets. It's our personal responsibility and we have to meet it.

Reports will be in the organization section of the Journal of the A.M.A. and every physician can afford to spend a few minutes going over them. It's worth your time to read it.

CIVILIAN DEFENSE

Sid Wrightsman

The initial step toward implementing the Arkansas Civil Defense and Disaster Relief Plan with reference to potential enemy atomic warfare has now been taken.

On December 14th, Arkansas Medical Society officers, together with members of the Military Medicine Committee, conferred with State Health Officer T. T. Ross at Little Rock. Under provisions creating state civil defense programs as presented by the National Security Relations Board, state health officers, in every case, have been awarded major responsibility in directing medical aspects of atomic disaster and Doctor Ross is to be commended for recognizing the initial need for conferring with the State Society on the all-important phases of Medicine's role in the months to come.

It is recognized that the problems falling to the medical profession are legion in modern atomic and biologic warfare and probably the most perplexing at this time in striving to initiate such a program of control is to determine exactly where to begin.

The major accomplishment at the December 14th meeting was the selection of a Committee on Civilian Defense of the Arkansas Medical Society to serve in close liaison with Doctor Ross and his associate, Dr. A. M. Washburn, on all medical problems in the state that may be expected to occur during the coming year. The committee will be composed of a pathologist, surgeon, radiologist, internist, pediatrician and general practitioner . . . each to serve in consultant capacity to Doctor Ross and to channel necessary information pertaining to a specialty to Society members.

The Arkansas Civil Defense Plan, in addition,

will provide for an over-all Health Resources Committee composed of representatives from all professional and voluntary lay organizations necessary in the directing of the myriad aspects of such a program. The Society will be represented thereon by the President, President-Elect, Secretary and the Executive Secretary, in addition to a member of each specialty to be selected by the medical administrator, subject to approval by the Society President. Moreover, each department head at the University of Arkansas School of Medicine will be obligated to serve.

At present, no formal meeting of the NSRB-appointed State Defense Plan officials, including Governor McMath, has occurred nor is it yet known as to the type of legislative act on the subject to be presented for passage to the 1951 State Legislature. The amount of State finances to be authorized in carrying out the program will perforce be subject to much legislative debate. It is recognized, however, that adequate funds should be included, **and marked specifically,** for the conducting of courses on atomic medicine for all Arkansas physicians, a subject deserving immediate consideration by the newly-appointed Society Civilian Defense Committee and the State Program Medical Administrator.

Despite difficulties to be encountered, it is encouraging to realize that the Arkansas Medical Society has been requested at the outset to make specific recommendations and to assume a major role in conducting the program.

EDITORIAL COMMENT

CIVIL DEFENSE BOOKLET AVAILABLE

The government handbook, "Health Services and Special Weapons Defense," appears, from advance notice, to be a booklet which private practitioners should obtain. Civil defense is discussed in non-technical terms but comprehensively and concisely. Copies may be obtained from the Superintendent of Documents, Washington, D. C., at a cost of sixty cents.

RANDOM THOUGHTS OF THE SECRETARY

December 5th. The House of Delegates busies itself with the business in hand and the day is devoted to reception of new business, reports of accomplishments and of hopes yet to be attained. A record attendance of delegates and enthusiasm promises that decisions will receive full debate and consideration. Tonight the Aces and Deuces entertain the larger state society delegations with thanks due Julian Price and Peterson for detailed planning of a perfect party.

December 6th. Walking to the Auditorium this afternoon, a weak ankle twists on an uneven bit of sidewalk, causing a fall, marked pain and swelling and disability of varying degree until sleep comes in relief at Memphis' Peabody in the early morning.

December 7th. Shortly after arrival we subject ourselves to a roentgen examination and see conclusive evidence of a solution in continuity of the fifth metatarsal and the next problem is how to avoid a walking cast.

December 8th. Celebrating our natal day with crutches for assistance in locomotion.

December 10th. We discard crutches in favor of a metatarsal bar and report improvement of weary palms and axillae.

December 15th. This seems a good time to stockpile some stout nerves.

December 23rd. The holiday season gives time to briefly pause in the worries and anxieties which perplex all of us and to unite in prayer that we, as Americans, may well measure to the arduous tasks which lie ahead.

OBITUARY

CARL DAKAN HARTWIG, age 66, died suddenly November 20th at his home in Lake City. Born in Ohio, he graduated from the Eclectic Medical College of Cincinnati in 1912 and located in Arkansas in 1920. His first location was at Lunsford but he later moved to Lake City. He was a member and deacon of the Baptist church, had served for many years as the Sunday School superintendent, a member of the Masonic lodge, the Odd Fellows and of the Lake City club. Surviving relatives are his wife, one son and two daughters.

GEORGE PERRY BRIDGES, age 65, Paragould, died November 22nd. Born near Harrisburg, he graduated from the University of Louisville School of Medicine in 1914. He had practiced in Paragould for about thirty years. He was a past-president of the Greene County Medical Society, a member of the Masonic bodies, the Shrine and of the Methodist church. Surviving relatives are his wife and two sons.

CHARLES EDWARD KITCHENS, age 69, De Queen, died November 20th following an illness of two months. Born October 1, 1881, in Waldo, he graduated from Memphis Hospital Medical College in 1909 and had practiced medicine in De Queen for forty years. He was a charter member of the Sevier County Medical Society, had served in all its offices and had represented it many times in the House of Delegates of the Arkansas Medical Society, was formerly a member of the Council and a Vice-President of the Arkansas Medical Society, a

member of the Tri-State Medical Society and of the Southern Medical Association, a member of the De Queen post of the American Legion, served with the army medical corps during World War I, a member of the Rotary club and a deacon in the First Christian church. Surviving relatives are his wife, three sisters and two brothers.

RICHARD S. SMITH, age 75, Parkin, died November 13th. Born in Saint Francis County he attended the University of Tennessee College of Medicine and was licensed to practice in Arkansas in 1903, first locating at Hamlin. He opened an office at Parkin in 1910. He was a past-president of the Cross County Medical Society. Surviving relatives are five daughters.

ROBERT P. HARRIS, age 64, died suddenly at his home in Knoxville, Tennessee, December 23rd. Born in Chicago January 21, 1886, he graduated from the College of Physicians and Surgeons, Little Rock, in 1911. He was formerly with the Veterans Administration at Little Rock and later served in superintendency of various hosiptals and as staff physician for the Ringling Brothers-Barnum and Bailey circus. At the time of his death he was superintendent of the Tennessee State Hospital. He served during World War I with the army medical corps and was a member of the Pulaski County Medical Society, the Arkansas Medical Society and of the Masonic bodies. Survivors are his wife, a son and a daughter.

BOOK REVIEW

Researches in Binocular Vision: By Kenneth N. Ogle, Ph.D., Section on Biophysics and Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic, Rochester, Minnesota. 345 pages with 182 figures and 26 tables. Philadelphia and London: W. B. Saunders Company, 1950. Price $7.50.

Binocular vision with "its greatest achievement, the specific sensation of stereoscopic depth perception" is the crowning refinement of man's special senses, enabling him to live in a three dimensional world instead of a flat two dimensional one. This book, the full subtitle of which is "Researches in Binocular Vision", is an organization and integration of the particular researches in this subject conducted over an eighteen-year period at the Dartmouth Eye Institute, Hanover, New Hampshire. It presents mainly non-clinical aspects of these researches. The book is divided into four parts and leads the reader from a beginning discussion of corresponding retinal points, the horopter, etc., by a gradual development to the full "experimental and theoretical bases of aniseikonia". For a research text this book is remarkably easy to read and certainly should be in every institutional medical library if not in the ophthalmologist's personal collection.

Thoracic Surgery: By Richard H. Sweet, M.D., Associate Clinical Professor Surgery, Harvard University Medical School, Illustrations by Jorge Rodriguez Arroyo, M.D., Assistant in Surgical Therapeutics, University of Mexico Medical School. 345 pages with 155 illustrations. Philadelphia and London: W. B. Saunders Company, 1950. Price $10.00.

According to the Preface, this book is intended to emphasize the technics of thoracic and thoracoabdominal operative procedures, which technics Dr. Sweet has found satisfactory in his own practice.

Dr. Sweet believes ". . . that any properly qualified surgeon can acquire with relative ease a satisfactory proficiency in thoracic surgery by employing the technics herein described."

Dr. Sweet does not attempt to discuss in detail the various fundamental aspects of many of the disorders for which his operative procedures are described, as such aspects are covered in the usual textbook. He undoubtedly intended that his book would have in general the characteristics of a manual of operative thoracic surgery.

This reviewer considers that the author accomplished his objectives. The reviewer, therefore, intends no criticism of Dr. Sweet when he (the reviewer) points out the following:

(1) The aspiring surgeon should acquire, or have acquired elsewhere than from Dr. Sweet's book, a thorough understanding of disorders for which many of the technics described by Dr. Sweet are applied before he attempts to apply those technics himself.

(2) He should realize that to perform major thoracic or thoracoabdominal operative procedures, he should have available excellent special personnel and facilities, including the services of an especially trained anesthetist.

The first chapter of the book pertains to the surgical anatomy of the thorax and contains twenty-eight excellent illustrations.

This book should be of value to any basically qualified, but non-thoracially-experienced general surgeon who truly aspires to qualify himself to perform good major thoracic surgery.

It also should be of value to some who are already performing thoracic surgery of limited scope.

The book contains no bibliography.



TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE observant student of pulmonary tue groups. Critical examination of the old presented by patients in the older agberculosis is impressed by the problems misbelief that pulmonary tuberculosis is unusual in persons of advanced years has directed the attention of the profession to the problems arising from the many cases of pulmonary tuberculosis present among older people.

PROBLEMS PRESENTED BY PULMONARY TUBERCULOSIS IN PATIENTS OVER FIFTY

The scope of the problem of tuberculosis in the aged has been brought into increasingly sharper focus by the gradual and wider use of the chest roentgen-ray film as a diagnostic tool. This has taken place since 1930, along with the more widespread use of refined methods of sputum examination for tubercle bacilli. These methods have shown an increased number of cases to have clinically significant pulmonary tuberculosis, whereas by reliance upon the old direct sputum smear method many cases would have been "negative" for tubercle bacilli.

In 1930 Myers stated: "The physician in private practice who insists upon careful examination, including sputum examination, tuberculin test, and X-ray examination of the older people among his clientele, will do much, by arriving at a definite diagnosis, to prevent the spread of tubercle bacilli to the bodies of their associates." At that time other authorities in the field of tuberculosis were also recommending a careful examination including laboratory services for all older people under the care of physicians.

The danger inherent in the contact of an older individual whose sputum is positive for tuberculosis, be it known or unknown clinically, with younger associates, in the intimacy of the home has been stressed by many. In 1940 Wiese wrote: "It is to be hoped that the generally accepted opinion that all elderly persons must cough and that such coughing is without danger to those about them will soon be changed and that all elderly persons with a chronic cough, with or without sputum, will be subjected to as vigorous examination as a younger person."

In the report of one mass chest X-ray survey of the residents of Erie County, New York, conducted in 1946-1947, it was stated: "The proportion of cases found increases directly with the age of those examined. This statement holds whether one considers the proportion of persons with tentative diagnoses of definite tuberculosis or the proportion with suspected tuberculosis. The success of a mass case-finding project hinges on ability to induce large numbers of older persons to be examined, though this fact is not widely recognized. The higher the median age of the group examined, the larger will be the number of cases found."

The Problem of Diagnoses

To rely upon the history and physical examination alone to diagnose pulmonary tuberculosis in the aged is not enough. Associated pathological conditions and altered physiological functions incident to advancing age have hindered the proper interpretation of physical signs. Many aged persons cough, expectorate, lose weight and complain of fatigue and weakness: accurate differential diagnostic study is necessary to determine the reasons why.

There are two primary working tools to employ in the diagnosis of pulmonary tuberculosis. The examination of pulmonary discharges, obtained by expectoration or from the fasting stomach by gastric aspiration and the use of the diagnostic chest roentgen-ray film. The film must have such technical qualities that it can be given a proper interpretation by a physician of experience.

The finding of tubercle bacilli in the sputum by either concentration or culture method establishes the diagnosis of clinically significant tuberculosis. A chest roentgen-ray film may upon occasion give evidence of such diagnostic finality that pulmonary tuberculosis can be said to be present from that evidence alone. Very often,

however, the roentgenray shadows are regarded only as possible evidence of tuberculous infection and further study of sputum specimens is indicated before a definite diagnosis can be made.

One other working tool of diagnostic aid in tuberculosis is the intracutaneous tuberculin test. If a patient gives no response to 0.005 mg. of purified protein derivative (P.P.D.) or to 0.1 ml. of 1-100 dilution of Old Tuberculin (O.T.), clinically significant tuberculosis is not present. A positive reaction to either of the testing agents means only that tuberculous caseous material is present somewhere in the body.

The Problem of Treatment

In the treatment of tuberculosis in the aged, most authorities agree that proper nourishment and rest are the basic treatment, rest being employed for its effect upon the heart and the body as a whole. There is less agreement upon the advisability of instituting collapse therapy in older persons with tuberculosis.

The Present 1935-1945 Local Study

In a study of patients with pulmonary tuberculosis admitted to Homer Folks Tuberculosis Hospital (Oneonta, New York), it was found that approximately half (51.3 per cent) were classified as "far advanced." Of the patients who were 50 years of age or older at the time of admission, 64.6 per cent were "far advanced." The patients 50 years of age or older represent 17 per cent of those discharged from the hospital.

In the group of patients aged 50 or over, there is a lower percentage of minimal and moderately advanced cases and the percentage of far advanced cases was higher than that found when the entire group of admissions is studied. Among the far advanced cases the ratio of males to females in the older age groups is four to one in this series.

Conclusions

The problem of the older patient with tuberculosis of the lungs can best be solved by prompt diagnosis and immediate isolation from others. Prolonged strict isolation of older aged males is difficult to achieve. However, many in the far advanced group will die in hospital during the first year.

Collapse therapy can and should be employed in the treatment of the more aged patients whenever the indications outweigh the contraindications.

Of 1,329 patients discharged from the Homer Folks Hospital over a nine-year period, 226, or 17 per cent, were 50 years of age or older at the time of admission.

In the group studied, the ratio of males to females 50 years of age or older was 3.1.

Tuberculosis case-finding methods applied to the older age males continue to be indicated.

Problems Presented by Pulmonary Tuberculosis in Patients Over Fifty, Elfred L. Leech, M.D., F.A.C.P., Annals of Int. Med., August, 1950.

PERSONALS AND NEWS ITEMS

Baxter County Medical Society held its initial organizational meeting at Mountain Home, October 23rd, electing the following officers for 1950-51: President, E. M. Gray; Vice-President, S. W. Chambers and Secretary-Treasurer, W. H. Pruitt, all of Mountain Home.

The Ninth Councilor District Medical Society met at Harrison December 8th for the following program: "Intestinal Obstruction," W. G. Cooper; "Carcinoma of the Cervix," Melvin McCaskill, Jr., and "Medical Management of Ulceration of the Gastrointestinal Tract," Jerome S. Levy, all speakers of Little Rock.

Sebastian County Medical Society has elected the following officers: President, J. B. Stewart; Vice-President, L. A. Whittaker; Secretary, Art B. Martin and Treasurer, J. C. Hodges.

Independence County Medical Society has elected the following officers: President, Ruth Junkin; Vice-President, L. T. Evans; Secretary, Paul Gray; Delegate, Charles Taylor; Alternate, C. A. Churchill.

Ouachita County Medical Society met in dinner session December 14th at the home of Dr. and Mrs. John H. Miller of Camden. The following scientific program was held: "The Functions of the Veterans Administration," Delmar Goode, administrator of the new Veterans Hospital, Little Rock and "The University of Arkansas School of Medicine," Hayden Nicholson, newly-appointed Medical School Dean, Little Rock.

The following 1951 officers were elected: President, John H. Miller; Vice-President, Tom J. Meek; Secretary, R. B. Robins; Delegate, James Guthrie, and Alternate, John L. Dedman, Jr., all of Camden.

PROCEEDINGS OF SOCIETIES

The following have been elected surgeons of their respective posts of the American Legion: J. B. Elders, Walnut Ridge; E. Baker, Dermott, and Henry Hearnsberger, Stephens.

The following participated in the sessions of the Southern Medical Association at Saint Louis: W. A. Reilly, Little Rock, (scientific exhibit) "Endocrine Problems of Childhood"; Jerome S. Levy, Alfred G. Kahn, Jr., and Robert Talley, Little Rock, (scientific paper) "Cirrhosis: A Dynamic Disease"; William A. Reilly, Little Rock, (scientific paper) "Thyroid Deficiency in Childhood"; Euclid M. Smith, Hot Springs National Park, (scientific paper) "Chronic Rheumatoid Arthritis; James W. Headstream, Little Rock, (with J. P. Robertson, Birmingham—scientific paper) "Cystograms in Traumatic Perforations of the Lower Urinary Tract"; James Barker, Little Rock, Benjamin B. Wells, Little Rock (discussants of papers).

The Arkansas Society of X-ray Technicians was addressed at its recent meeting in Hot Springs National Park by J. O. Boydstone, "The Atomic Bomb and Its Medical Aspects"; J. O. Norton, "The Hazards of X-ray"; I. Meschan, "The Application of Radioisotopes to Medicine," and George Burton, "Positions in Radiography of Unusual Value."

"Electroconvulsive Therapy Following Multiple Fractures," by Louis A. Cohen, Little Rock, appeared in The American Journal of Psychiatry, November 1950.

Paul A. Mahoney, Little Rock, has been elected a regional member of the Board of Directors of the American Otorhinological Society for Plastic Surgery.

J. B. Terry has moved from Helena to West Memphis.

L. J. Kosminsky, Texarkana, and G. D. Murphy, Jr., El Dorado, have been appointed members of the National Child Welfare Committee of the American Legion.

F. J. Scully, Hot Springs National Park, has been elected grand high priest of the Grand Chapter, Royal Arch Masons in Arkansas.

G. L. Kimball, De Queen, has been elected grand master of the Grand Lodge, Free and Accepted Masons of Arkansas. Also elected were W. J. Ketz, Batesville, deputy grand master, and F. J. Scully, Hot Springs National Park, grand senior deacon.

Max F. McAllister, Fayetteville, has been elected Vice-President for Arkansas of the Frisco System Medical Association.

The following were registered at the Cleveland session of the American Medical Association: W. R. Brooksher, Fort Smith; Chas. T. Chamberlain, Fort Smith; F. Walter Carruthers, Little Rock; C. E. Crawley, Forrest City; D. W. Goldstein, Fort Smith; J. A. Henry, Russellville; Robert Hood, Russellville; Fount Richardson, Fayetteville; R. B. Robins, Camden, and H. W. Thomas, Dermott.

"Various Pediatric Endocrine Problems," by W. A. Reilly, Little Rock, appeared in the December, 1950, New Orleans Medical and Surgical Journal.

WOMAN'S AUXILIARY NEWS

The Craighead-Poinsett County Medical Auxiliary met with the Society at the Country Club in Jonesboro December 6 for their annual bar-b-q. Seventy members and guests were present.

Mrs. Paul Stroud, President of the Auxiliary, presented one of the films from Harding College on the American Way of Life entitled "Going Places." Dr. L. H. McDaniel, guest speaker for the evening, gave a talk, "The Doctor's Wife."

This being the annual party of the year no business was transacted other than the collecting of Auxiliary dues.

The Pope-Yell County Medical Auxiliary met Thursday evening, December 14, in the home of Mrs. Brooks Teeter, with seven members present. The meeting was presided over by Mrs. William O. Young, President. Each member brought canned goods for a Christmas basket to be delivered to a needy family.

Mrs. Max J. Mobley, Reporter.

The Woman's Auxiliary to the Sevier County Medical Society met on Tuesday, November 14, at the home of Mrs. C. A. Archer in De Queen. The President, Mrs. Pierre Redman, presided over a brief business session.

Dr. R. B. Dickinson, President of Sevier County Medical Society, was a guest speaker and gave



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—Editorial: Dramamine,
GP 2:27 (July) 1950



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The December meeting will be a dinner party with the doctors at Hill's in De Queen.

Mrs. R. C. Dickinson.

The Auxiliary to the Fourth Councilor District Medical Society met in Monticello Monday night, October 16. After a buffet supper with the doctors at the Ridgeway Hotel, the ladies went to the home of Mrs. J. P. Price, for their meeting.

The program consisted of a book review, "Humanity Up-Rooted," given by Mrs. J. P. Price.

There were twenty-two present. Mrs. W. F. Norrell was a guest and played a piano solo during the social hour. The meeting next month will be held in Star City.

Mrs. Van C. Binns,
Publicity Chairman.

Mrs. Edwin Dildy assumed the presidency of the Auxiliary to the Howard-Pike Medical Society at a meeting in her home Thursday, November 9. The Auxiliary voted to meet on the second Thursday of each month in conjunction with the meeting of the Howard-Pike Medical Society. The Auxiliary will meet in the homes of members and the doctors will join them after their meeting for a social hour together.

Plans have been made for interesting programs to be presented at each meeting. A Christmas party is planned for December. A Doctor's Day celebration will be held in March, and the Auxiliary will hold open house at Memorial Hospital on National Hospital Day, which is May 12.

For their project the Auxiliary will help with the finance of the landscaping of the grounds of Memorial Hospital by giving a large benefit bridge in the spring.

Mrs. J. S. Hopkins,
Publicity Chairman.

DOCTOR . . .

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The Journal of the Arkansas
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The Journal of the Arkansas Medical Society

Vol. XLVII FORT SMITH, ARKANSAS, FEBRUARY, 1951 No. 9

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MEAT...and the PROTEIN NEEDS of the DIABETIC

Not less but *more protein* than the traditional gram per kilo of body weight recommended for the non-diabetic individual promotes an increased sense of well-being in the diabetic patient. Liberal amounts of biologically excellent protein, such as that provided by *meat,* are therefore especially useful in dietotherapy.

For supporting the well-being and vigor of the patient, increasing his resistance to infection, and minimizing many of the degenerative changes common in diabetes mellitus, maintenance of body protein reserves is particularly important.[1,2] The former belief that protein foods, especially meat, engender hypertension and arteriosclerosis, is no longer tenable. On the contrary, deficits in dietary protein are apt to initiate anemia, hypoproteinemia, and retrogressive processes in the kidneys and other organs or tissues.

Ample amounts of high-quality protein foods in the prescribed diet—including generous amounts of meat—are important for maintaining a good nutritional state in the diabetic patient. Such a diet provides the nutritional essentials required in overcoming infections and in prompter healing of traumatic wounds.

Meat, however, is valuable to the patient for more than just its biologically excellent protein. It also furnishes important amounts of iron, thiamine, riboflavin and niacin, and of the newly discovered vitamin B_{12} which, among its several functions, promotes efficient utilization of protein.

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(1) Mosenthal, H. O.: Management of Diabetes Mellitus: An Analysis of Present-Day Methods of Treatment, Ann. Int. Med., 29:79 (July) 1948.

(2) McLester, J. S.: Nutrition and Diet in Health and Disease, 5th ed., Phil., W. B. Saunders Company, 1949, page 364.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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ACUTE OBSTRUCTION OF THE SMALL INTESTINE*

FRANK G. KUMPURIS, M. D.
Little Rock

During the early days of abdominal surgery, operation for intestinal obstruction was pronounced by some of the ablest surgeons as deliberate murder. The chief debate at this time was whether surgical or medical management offered the patient the best chance for survival. However with the improvement of surgical technique, it became apparent that early operation and immediate operation saved many lives. It was during this period that authorities such as J. B. Murphy said, "procrastination kills more lives than cancer," and the statement "never let the sun set on an intestinal obstruction" became a respected dictum. Although it is true that the overall mortality rate remained high, numerous reports indicated that extremely low mortality rates were obtainable if early surgery was performed. Boyce and McFetridge reported a 64% mortality rate on these individuals operated 96 hours after the onset of symptoms, and 5.9% mortality rate in patients operated within the first twelve hours of symptoms. McKittrick and Sarris in Boston reported 43 cases of acute mechanical obstruction operated on within 24 hours of onset of symptoms with no deaths.

The treatment of intestinal obstruction was revolutionized by the establishment of the rationale of suction therapy by Wangensteen in 1931 and the development of the long double lumen tube by Miller and Abbott in 1934. The use of suction therapy by those with great skill and good judgment effected remarkable reduction in mortality rates. Before the advent of suction therapy, the surgeon had only one method with which to treat intestinal obstruction; today he has three methods at his disposal.

1. Immediate operation.
2. Operation after preliminary period of intubation and decompression during which chemical and fluid balance are restored.
3. Purely non-surgical treatment with reliance solely on intubation and general supportive measures.

The picture of the patient who comes into the hospital as an acute emergency, and whose major complaints are of cramp-like abdominal pains, distension, with nausea and vomiting is a familiar one to all of us. An awareness of the physiologic changes which take place in such cases is of the utmost importance, if we are to give these patients optimum relief in a minimum of time.

To make certain that we are thinking of the same things when terms are used, there are two definitions I would like to present:

(1) Intestinal obstruction may be best defined as any interference with the normal progression of intestinal contents.

(2) Simple obstruction is a term used to include all forms of intestinal obstruction except those in which there has been some compromise of the blood supply: i.e., strangulation, mesenteric thrombosis, etc.

There are three general mechanisms producing small bowel obstruction:

(1) Occlusion of the intestinal lumen which we may call mechanical,

(2) Reflex diminution of peristalsis, or the nervous mechanism,

(3) Interference with or embarrassment of the blood supply, or the vascular mechanism.

These three mechanisms, mechanical, nervous, and vascular, may exist separately or in combination, in which latter case, their effect is usually cumulative.

In simple obstruction of the small bowel, about 90 per cent occur in the region of the ileum, and most of the remaining 10 per cent in the jejunum. A relatively large percentage of lower small bowel obstruction progress to strangulation, perhaps because the warning symptoms of obstruction down are somewhat less dramatic, and the

* Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 18, 1950.

patient therefore defers calling the doctor longer.

The general sequence of events in small bowel obstruction may be roughly divided into the earlier local changes and the somewhat later general changes and follow the sequence of:

(1) Obstruction,
(2) Distension,
(3) Transudation,
(4) Loss of extra-cellular fluids,
(5) Loss of intra-cellular fluids.

First, there is the basic obstruction, produced by one or more of the mechanisms which were previously mentioned.

Second, there develops above the site of obstruction a progressively increasing distension, produced by the accumulation of two agents: fluid and gas.

The fluid comes from three sources:

(1) Oral ingestion of fluids,
(2) Fluid fractions from the circulating blood,
(3) Normal secretions of digestive ferments:
    a. Saliva: 1500 c.c.
    b. Gastric juices: 2000-3000 c.c.
    c. Bile: 300-500 c.c.
    d. Pancreatic juices: 500-800 c.c.
    e. Intestinal juices: 3000 c.c.

The total secretion of digestive juices within 24 hours is therefore roughly 7 to 8 liters, or two to three times the total volume of the blood plasma from which they are derived. The answer to this problem is, of course, that in the normal bowel this amount of fluid is re-absorbed almost in its entirety in the lower small bowel and colon.

The gas consists of:

(1) 68 per cent swallowed air, brought in through normal deglutition,
(2) 20 per cent gases interchanged between the intestinal content and blood,
(3) 12 per cent gases evolved by the action of bacteria on intestinal content.

Third, there is a transudation of fluids and chlorides into the intestinal lumen above the obstruction. The amount of transudate is roughly proportinate to the degree of distension and is produced primarily by the increase in intraluminal pressures. Pressures of up to 800 m.m. of water, or 40 times normal, have been recorded in experimental animals with resulting transudates as much as six times the daily 7 to 9 liters normally secreted. This outpouring of water and chlorides from the circulating blood volume is in some measure detectable by laboratory studies, which often will show:

(1) A drop in chlorides,
(2) A rise in RBC and hemoglobin,
(3) An increase in CO2, due to the retention of bicarbonate in an attempt to compensate for the chloride loss and maintain acid base balance.
(4) A rise in the blood urea, probably due to a combination of three factors:
    a. Inadequate excretion of urine and feces,
    b. Retention of metabolites for acid-base balance,
    c. Protein breakdown due to starvation.

Within a 24-hour period, the loss of electrolytes may be equivalent to the total electrolytes of the plasma, for each liter of fluids poured out into the intestinal lumen contains 5 to 6 grams of salt, or about 50 to 80 per cent of the total average intake per day (8 to 12 grams). Such a loss from the circulation blood cells calls out the extracellular fluids and their electrolytes and with the exhaustion of reserve electrolytes in these fluids there comes a minution of plasma volume.

Without medical intervention, the process continues still further on the downward path with:

(1) An accumulation of excess sodium, since sufficient bicarbonate cannot be retained to maintain proper acid-base balance. This excess sodium is execreted through the kidneys taking with it, additional water.

(2) Due to this chemical imbalance, the net oxygen tension of the blood is lowered to about 60 per cent of normal, giving the equivalent of a rather severe anoxic anemia.

(3) The reserve of extra-cellular fluids having been depleted, the intra-cellular fluids are called out and slight changes in them often result fatally.

Just how, then, do these local and general disturbances of physiology fit into the clinical picture?

Since the greater portion of digestive fluids are secreted high in the small intestine and are to a great extent absorbed by the time they reach the cecum, high obstruction gives an earlier and more profuse emesis with more severe signs of fluid and electolyte loss. In the lower portions these effects are usually later and the primary early sign is distension.

The cause of the cramp-like pains in obstruction is primarily distension, and its resultant stretching of the bowel wall. Except in adynamic ileus, this distension also stimulates peristalsis, causing a still further increase in the ension of the intestinal wall. Anoxia of the musculature of the intestinal wall can also produce violent contractures of the viable muscle with pain. Jones

and Pierce in 1931, noted that pain originating from an obstruction at almost any level in the small bowel is usually referred to the area around the umbilicus and occasionally to the low back.

In addition to the shock-like effects produced by pain and fluid loss, marked variations in respiration and blood pressure are produced by distension. These latter changes are thought to be due to reflex stimuli arising from the distended bowel and passing via the splanchnics to the central nervous system.

Vomiting is primarily due to a reflex stimulation of the vomiting center in the medulla. Crowley and Johnson, have offered a rather ingenious explanation for some of the vomiting on a purely mechanical basis. They feel that peristalsis always downward, as do most authorities now, and there is no reverse peristalsis. During the propulsion of the liquids downward, they feel that this force is increased, thus forcing fluid against a dam (the obstruction) with such force that it will either burst through the bowel wall or seek an escape through the only opening, namely the oral end. In ileus, one sees a slightly different process, in which there is a gradual damming up of the intestinal content above the obstruction and eventual overflow.

The physiology of simple obstruction as described above, must be remembered as important, but not as complete, for one must remember that simple obstruction may progress to gangrenous obstruction. This most frequently occurs in the gas trap type of obstruction. A typical example of this is found in an obstruction of the large bowel with a competent ileocecal valve. This prevents the backflow of gas and liquid into the ileum, resulting in a progressive and marked over-distension of the bowel. The over-distended wall compresses the circulation in the venules of the bowel wall with resulting gangrenous changes.

Other factors in the etiology of gangrenous obstruction are strangulated hernia, adhesions, volvulus, intussusception, and the occlusion of the venous or arterial circulation. Fifty-three per cent of the intestinal obstructions are due to strangulated hernia. Internal hernia on the other hand can only be suspected and proven by exploration. Next in the order of importance in etiology of gangrenous obstruction is adhesions. They represent about thirty per cent of the obstructions. Volvulus and intissusception are more uncommon, but must always be borne in mind. Occlusions of the circulation may result from thrombosis of the mesenteric vessels or from an embolis of the mesenteric artery.

The pathologic picture varies with the size of the bowel segment involved. There may be a pinched-off segment of bowel as in a Ritchter's type of hernia or there may be a huge segment of bowel bound down by a band of adhesions as is often seen associated with volvulus. In general, at the time of surgery, the bowel is seen as a deep reddish-purple segment which has lost its glistening appearance. In early gangrenous obstruction one sees a marked blanching of the wall with each peristaltic wave. The bowel is particularly susceptible to embarrassment to its circulation because normally there is a localized anemia with each contraction. If the gangrene is allowed to progress in the human, the permeability of the bowel wall is increased so as to permit the passage of bacteria into the peritoneal cavity in about two to four days. Perforation of the bowel may occur at any time after this up to about six to seven days. With perforation there results frank peritonitis.

The lumen of the strangulated bowel contains less gas and more liquid than in a simple obstruction. The liquid is made of plasma and whole blood in addition to the normal contents of the bowel. The peritoneal space contains a bloody exudate which becomes purulent in the longer standing cases in which bacteria have entered through permeation or through perforation.

Microscopically one sees a markedly thickened submucosal layer which is filled with many polymorphonuclear cells and red blood cells. The muscularis is thickened early in the disease process, but as distension progresses, it becomes thinner and shreds prior to perforation. As the process continues, the mucosa sloughs, producing ulcerated areas. Pathologically all gangrenous segments do not follow the same pattern, because all are not caused by the same factors, the size of the bowel involved varies, and the embarrasssment, whether arterial or venous or both varies in each obstructive gangrenous process.

The blood chemistry changes are those of simple obstruction. To reiterate, the chlorides are decreased, this results in an increase in the bicarbonates giving an increased carbon dioxide combining power as an attempt to compensate. The sodium ion is lost in the urine, in an attempt to counteract the alkalosis. The reduction of the ionic concentration of the body fluids results from depletion of the base. However, in

addition, in the gangrenous obstruction, one sees shock and toxic manifestations of infection.

Shock is probably the most important factor in the changes produced by gangrenous obstruction. As was mentioned, there is a marked loss of both plasman and blood from the circulation. This occurs in three directions—into the lumen of the bowel, into the bowel wall, and into the peritoneal space. Scott and Wagensteen have demonstrated experimentally that a gangrenous segment of bowel may increase in weight about 283 per cent over normal. This represents a loss of considerable of the total blood volume. Clinically, the amount of blood volume will vary with the amount of bowel involved and whether there is venous, arterial or arteriovenous occlusion. In the arterial occlusions there is less increase in bowel weight than in the other two types. It was also shown by these workers that the length of life is incersely proportional to the amount of blood lost. The more the blood loss ,the shorter the life.

Other factors must play a part in the changes produced by gangrenous obstruction leading to death in the untreated cases. Whether or not the absorption of toxic products plays an important part has led to considerable controversy in the literatore. There is certainly a leucocytosis in gangrenous obstructions which is present after corrections are made for the hemoconcentration produced by the blood loss and shock. Whether or not this is due to the absorption of toxins or not is difficult to say. Experimentally, when obstructions were produced in dogs, and the dogs were given saline solutions and blood to replace the loss, death occurred in 16 to 25 hours. When other dogs with similar experimental obstructions were given sulfasuxidine and streptomycen, they lived up to ninety days. In the untreated dog, the peritoneal fluid was alive with organisms with a large number of anaerobic bacteria. On the oher hand, the bacterial flora in the treated dogs was the same as it was at the time of operation.

Pieces of isolated loop segments of a gangrenous bowel were removed and placed within the abdomen of other dogs. In another series, the segment of bowel was sterilized before insertion into the peritoneal cavity. In each instance the animals devoleped a toxic reaction and died.

Experimentally, toxic drugs have been placed into the closed segments of obstructive gangrenous bowel in order to test the rate of absorption. It has been observed that the rate of absorption is delayed, up to the point where the permeability increases just prior to perforation. At this time the absorption rate definitely increase. Blalock explains the increased depth of shock on release of the obstruction, not on the absorption of histamine, but on the release of blood into the traumatized vessels of the involved segments, and thus releasing the blood into the tissue spaces of this segment.

No one factor can be said to be the cause of all the symptoms and the cause of death in obstructive gangrenous bowel. The train of symptoms of dehydration, the development of shock, and finally dehydration, the loss of blood into the wall of the bowel, the lumen of the bowel and the peritoneal cavity, the transudation of plasma into the general peritoneal cavity, and lastly, the absorption of all toxins, all contribute to the symptoms and the cause of death.

The management of acute obstruction of the small bowel will be better understood with the above knowledge of the physiology and pathological physiology of the disease. Needless to say, one should establish a diagnosis of obstruction by history, physical examination and confirmation by a flat X-ray examination of the abdomen. The presence of a distended isolated loop of bowel, of the presence of fluid waves in the bowel pattern, should confirm the diagnosis of small bowel obstruction. One should not forget that in the high small bowel obstructions, there is no distension, and only through the flat plate of the abdomen will he get accurate picture of the gas pattern of the bowel.

In the period during which studies are being made to determine the actual cause of the obstruction, and as a pre-requisite to any steps for the correction of that obstruction, whether medical or surgical, a restoration of the normal local and general physiology is obligatory. Intubation with a Miller Abbott tube should come first. Relief of the distension restores the intestine above the obstruction to a more nearly normal state, reducing the amount of transudation and permitting the other measures to have their full effort. Intubation is perhaps the greatest single aid we have in the treatment of obstruction of the bowel.

The lost fluids and electrolytes are best replaced by 5 per cent glucose in normal saline. This combination has a manifold action. The water restores the fluid lost. The salt restores the sodium and chlorides lost, and the glucose combats the azotemia and ketosis which comes

as a result of the starvation. Where there has been a prolonged loss of proteins with starvation, restoration of blood proteins by blood transfusions is quite helpful. No precise knowledge of exact chemical balance is necessary, for the normal kidney if supplied with adequate amounts of water, sodium and chlorides, will make the required corrections. But what is adequate? Briefly, 1000 c.c. of normal saline will take care of the daily requirement of salt for the body. The fluid lost through the intestinal tract should be replaced liter for liter by normal saline. A urinary output of 1000 c.c. to 1500 c.c. daily is recommended.

In the management of the early intestinal obstruction, most every one is agreed that if the patient is in good condition, has no distension, and the electrolytes are approximately normal, one should operate early and correct the cause of obstruction. In many cases of simple mechanical obstruction, conservative treatment with intubation, careful management of the patient's electrolyte balance may carry the patient through without surgical intervention. However, gangrenous obstruction, is a progressive entity which must be operated upon as soon as possible for good results. However, one should not operate on these patients unless he has intubated, taken several hours to control the shock, restore the electrolytes towards normal, and treated the disturbed physiology as well as the case permits. The success of the surgery in these patients is directly proportional to the length of time the patient has had the obstruction, to the ability of the surgeon to control the distension and his ability to restore the patient to electrolyte normalcy.

SUMMARY

1. The physiologic changes associated with simple obstruction were discussed.
2. The pathologic physiology of the gangrenous obstruction was discussed briefly.
3. With the above mentioned stressed, the importance of the bluid balance and control of distension before surgical intervention was emphasized.
4. It is to be remembered that distension is not seen with high small bowel obstruction.
5. Early surgery is good surgery in the simple obstruction or gangrenous obstruction who has no distension and the fluid balance is near normal.
6. In the delayed case where gangrenous obstruction is present, intubate first and relieve the distension, use saline in glucose and restore the body fluid balance, then operate for best results.
7. The patient's prognosis is directly proportinate to the duration of the gangrenous obstruction, to the control of the distension and to the degree of restoration of the electrolyte balance.

CANCER OF THE COLON AND RECTUM*

S. W. HAWKINS, M. D.
Fort Smith

Carcinoma in all parts of the body is definitely on the increase.

Rankin (1) in a recent publication stated that 50,000 people die each year as a result of cancer of the lower bowel.

The largest majority of patients with cancer in this location are in the 5th and 6th decades of life. The youngest patient in my personal series was 38 and the oldest 84 years of age.

Forty-seven cases have been collected from the literature (2) occurring in patients under 16 years of age. Two were in children 3 1/2 years of age and one case was reported in a new born monster.

Pathology and Symptomatology

A. Ascending colon and proximal 1/2 of the transverse colon is developed from the mid gut. The wall is thinner and greater in diameter than the descending colon. Lesions in this segment tend to be large, somewhat flattened, laterally placed tumors with a grandular ulcerating base creating a large surface for absorption. Since the stool at this point is in a liquid state complete obstruction infrequently occurs.

Symptoms are often bizarre.

(1) Weakness—loss of weight.
(2) A palpable tumor in the right lower quadrant may be noted by the patient.
(3) Vague pain in right side of abdomen.
(4) Abdominal cramps and diarrhea.

B. Lesions of descending colon.

Here the tumor is hard, tends to encircle the bowel wall, giving a typical napkin ring appearance. The stool by this time has reached a more solid state and symptoms of obstruction begin to appear.

The more common symptoms are:

(1) Change in normal bowel habit. One of increasing constipation.
(2) Alternating constipation and diarrhea.
(3) Gurgling sounds within the abdomen, rumbling of gas, frequently following the course of the colon.
(4) Bright red blood at stool.

C. Lesions of the Rectum.

Here the tumor may be a hard ulcerating lesion occupying only one portion of the bowel wall. Since the ampulla of the rectum is relatively large in diameter, symptoms of obstruction may be late in appearing.

Common symptoms:

* Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 18, 1950.

(1) Rectal bleeding (bright red, blood).
(2) Change in bowel habit increasing constitpation.
(3) Feeling of incompletely emptying rectum following stool.
(4) Rectal tenesmus.
(5) Decrease in caliber of stools.
(6) "Hemorrhoids."

Diagnosis:

(1) Carefully taken history.
(2) Digital examination.
(3) Sigmoidoscopic examination and biopsy.

One must remember that the rectum and rectosigmoid areas are relatively blind to the roentgenologist.

(4) Barium enema—with proper cleansing of the bowel before examination.
(5) Air contrast enema.
(6) Never give barium by mouth to a patient with a suspected lesion of the large bowel. A partial obstruction can become complete as a result, and the procedure then becomes a surgical emergency rather than one of election.

Treatment, Preoperative:

(1) High protein, high calorie, high vitamin diet with supplementary vitamins.
(2) Sulfathaladine or Sulfasuxadine for five days before operation.
(3) Blood transfusion to restore blood volume.
(4) Thorough cleansing of bowel with saline catharsis and enemata in the immediate preoperative period.

Method of Spread:

(1) Regional nodes.
(2) Blood vessel invasion.
(3) To adjacent organs.
(4) To distant organs—liver.

Operation:

Anesthesia. A mixture of Pontocaine, 10% Glucose and Adrenalin with supplementary sodium pentothal. This gives not only complete relaxation, but small bowel contraction as well.

Exploration: To determine the extent of the lesion. Extensive liver metastasis, rigid fixation of the lesion, massive invasion of lymph nodes and blood vessels, and particularly lesions which have been found to have invaded the bladder by cystoscopic examination—constitute contraindications for surgical removal. (3).

However, those lesions that are not rigidly fixed, somewhat movable, and have become adherent to the perirenal fat, the abdominal wall, a loop of small bowel, the uterus, posterior wall of the vagina, dome of the bladder or posterior wall of the prostate, are not only lesions which justify removal en bloc with the adjacent part of the contiguous organ, but will frequently result in 5-year cures. (3)

Patient with moderate liver metastasis are likewise entitled to resection of their primary lesion. They are not only made more comfortable, but can be expected to survive for a longer period. Eighteen months without resection; 23 months with removal.

Following these criteria one can expect a resectability rate of almost 90%. (4)

Choice of Operation:

In the absence of obstruction, inflammation of the bowel wall, and extreme obesity (particularly in patients with heavy mesenteries), resection and primary anastamosis is the procedure of choice for both the right and left colon and sigmoid.

If any of these factors are present, then we prefer the Lahey modification of the Mikulicz procedure.

Ascending Colon: Removal of terminal ileum, entire ascending colon and proximal transverse colon, with wide removal of the mesentery, and either end to end ileo transverse colostomy or a double barreled ileocolostomy.

Descending Colon and Sigmoid: Wide resection of bowel and gland bearing area, usually necessitating mobilization of the splenic flexure, and primary colo-colostomy or double barreled colostomy.

Rectosigmoid and Rectum: Dixon (5) has long been an advocate of anterior resection. Babcock and Bacon (6) are champions of proctosigmoidectomy with perineal colostomy. In their hands 5-year survivals equal those of other clinics that lean toward the more radical procedure.

We prefer to cast our lot with Lahey (3), Rankin (1), Coller (7), Gilchrist and David (8), Jones (9) and others, and are doing combined Miles abdomino-perineal resections with permanent colostomy. The superior hemorrhoidal artery is divided at its point of origin, the widest possible margin of mesentery is removed and the levator ani muscles are divided far laterally. The colostomy is implanted in the original left rectus muscle splitting incision, and the posterior wound closed except for a cigarette drain.

Post-Operative Treatment:

(1) Supportive fluids intravenously.
(2) Colostomy decompressed 36 hours after surgery.
(3) Milk of Magnesia on 6th day, then irrigations thru colostomy every other day afterward.
(4) Cigarette drain removed from posterior wound on the 4th day and the wound irrigated twice daily thru a small catheter.
(5) These patients are placed on a colostomy

diet and at the time of their release from the hospital on 18th-21st day there is very little drainage on the dressings between irrigations.

Operative mortality at the Mayo Clinic has dropped from 12% to less than 3% with the advent of the insoluble sulfa drugs. (10)

Over a 3-year period in our small series of 20 cases there has been no operative mortality.

5-year survival rate better than for malignancy of any other part of the gastrointestinal tract.

(1) Overall 50%.
(2) Lesion confined to the bowel 90%.
(3) Metastasis to regional lymph nodes 45%.
(4) Spread to regional nodes and blood vessel carcinoma.

Case Reports:

1. Mrs. W. P. R., age 46. Slide. Ascending colon.
2. Mrs. E. G., age 69. Slide. Descending colon.
3. Mr. H. W., age 55. Slide. Descending colon. Mr. G. M., age 50. Perforated diverticulitis carcinoma.
4. Mr. W. K., age 69. Rept. Ca. of rectum with bladder involvement. Complete obstruction.
5. Mr. R. B. C., age 84. Slide.
6. Slide showing type of colostomy posterior wound and type of colostomy dressing.
7. Slide showing site of occurrence of lesion.

Conclusion: 50% of lesions of the large bowel can be reached with the index finger; 75% can be reached with the 10-inch sigmoidoscope.

Let us resolve in all patients with bowel symptoms including hemorrhoids to think first of carcinoma. Once the diagnosis is made, then insist upon the patient receiving proper treatment.

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PERSONALS AND NEWS ITEMS

R. B. Robins, Camden, addressed the second annual postgraduate seminar of the Alabama Academy of General Practice at Birmingham on January 18th.

Earle H. Hunt, Clarksville; Frank Kumpuris and Chas. R. Henry, Little Rock, addressed the Arkansas State Practical Nurses Association at Little Rock January 17th.

Among those in attendance at the Memphis session of the American College of Physicians during January were: A. A. Blair, Chas. T. Chamberlain, Fort Smith; H. T. Smith, McGehee; J. N. Compton, O. C. Melson, S. C. Fulmer, B. B. Wells, P. J. Alamaden, Dan H. Autry, R. E. McLochlin and David T. Hyatt, Little Rock, and Euclid M. Smith, Hot Springs National Park.

Stewart M. Wilson, Rogers, has passed his examinations as a diplomat of the American Board of Internal Medicine.

E. A. Mendelsohn, Forth Smith, attended the annual session of the Texas Radiological Society at Galveston January 19-20th.

J. W. Lamb, formerly of Wynne, is now associated with the Vicksburg Clinic, Vicksburg, Mississippi.

O. J. Kirksey has been elected a director of the Bank of Mulberry.

Joe Rushton has been elected a director of the First National Bank at Magnolia.

Dr. and Mrs. John William Smith, Little Rock, spent a recent vacation at Miami Beach, Florida.

Dr. and Mrs. L. K. Hundley, Pine Bluff, spent a recent vacation in Miami Beach, Florida.

Bill Davenport, Clinton, Arkansas, from the University of Arkansas School of Medicine student body, has been elected student councilor to the Student American Medical Association.

The Wallace Sanitarium at Memphis has elected the following staff officers for 1951: Chairman, Dr. Bland Cannon; Vice-Chairman, Dr. Charles W. Miller, Jr.; Secretary, Dr. James A. Wallace.

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W. R. BROOKSHER, M. D., Editor
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EDITORIAL

FORMATION OF AMERICAN MEDICAL EDUCATION FOUNDATION

The action of the Board of Trustees at the Cleveland meeting in appropriating one-half million dollars as the Association's initial contribution to an annual fund to be raised by the medical profession to assist the medical schools has been widely applauded as one of the most constructive and important programs ever undertaken by the American Medical Association. In announcing the establishment of this fund, the Board of Trustees expressed the hope that the Association's contribution would be greatly augmented by gifts from many other sources and urged all members of the Association to contribute individually. The initial response of the profession has been most gratifying. Many physicians in attendance of the Cleveland meeting inquired how they should make their contributions, and since the meeting letters requesting similar information have been received daily at Association headquarters.

It can now be announced that the American Medical Education Foundation has been established as a not-for-profit corporation, under the laws of the state of Illinois, to receive and distribute contributions to the fund from the individual members of the medical profession and friends of the profession. The Commissioner of Internal Revenue has been asked to rule that gifts to the foundation will be deductible in the computation of income taxes. An 11 man board of directors chosen from the Board of Trustees, the officers of the Association and the Council on Medical Education and Hospitals will be responsible for arranging for the distribution of the funds to all approved medical schools. The funds are to be unrestricted, with each medical school free to determine how it can best use its share to further the basic training of its students. It is planned that the foundation will coordinate its activities closely with other major efforts to raise funds for medical education from voluntary sources, which it is hoped will be announced shortly.

Each member of the medical profession is urged to demonstrate his support of this new undertaking by contributing promptly and generously. Because of rising costs, inflation, fewer large individual benefactions and reduced income from endowments, the medical schools need, without further delay, assistance of the type this fund can give. It is the desire of the foundation that the first annual disbursement of funds to the medical schools be made this spring. It is clear that, if the foundation's contribution is to be an effective one, a substantial fund must be raised by the medical profession within the next few months. It is therefore urged that each physician consider an annual contribution of $100. Many of the contributions already received exceed this figure. When a physician feels that this amount is beyond his means, smaller contributions will be welcome, but the profession must recognize that substantial sums are required and that token contributions alone will not be sufficient.

Almost every physician now practicing received his medical education for less than what it cost his medical school. While many physicians have discharged this debt to society in full or in part, by public and charitable activities and by donations to the schools, with which they have been associated, many are still indebted to one or more medical schools for their training as students, interns or residents. Furthermore, the medical profession has traditionally accepted a large measure of responsibility for the training of the continuing flow of young physicians, on which it must depend for recruits and replacements in its efforts to serve humanity. It is to be expected, therefore, that all physicians, re-

gardless of the other contributions they may have made to society, will want to share in the responsibility of making the foundation a success.

The American Medical Association has indicated its belief that the possibilities of securing adequate support for medical education from voluntary sources are far from exhausted. To prove this, actions as well as words are required. The challenge has now been made directly to the medical profession. The members of the profession can meet this challenge by sending their contributions today to the American Medical Education Foundation, 535 North Dearborn Street, Chicago 10.

—J. A. M. A., Jan. 20, 1951.

DUES IN THE AMERICAN MEDICAL ASSOCIATION

Confusion is apparent over membership dues in the American Medical Association and a short explanation is in order. Previous to 1950, members of county and state medical societies have automatically became members of the American Medical Association without payment of dues. Such physicians as wished to participate in the annual scientific sessions or be members of the House of Delegates became Fellows of the Association upon election and the payment of annual dues of $12, this covering a subscription to The Journal of the American Medical Association. This incidentally, was the subscription price to The Journal paid by non-fellows.

Annual dues upon all of the regular membership of the American Medical Association of $25 were levied by the House of Delegates to begin with the calendar year of 1950. Certain exceptions are provided which have been furnished all county society secretaries in a special bulletin from the office of the executive secretary.

Effective with payment of the 1951 dues of $25, membership dues will include a subscription to The Journal of the American Medical Association. Members who paid the 1950 annual dues are now receiving The Journal. Fellowship dues have been decreased to $5 and fellows may elect to receive any one of the specialty journals published if they desire.

Dues to the American Medical Association are paid through county society secretaries to the state secretary. Fellowship dues, however, are to be remitted direct to the American Medical Association. Membership is continuous and to remain in good standing, dues for each of the years must be paid.

THE 1950 INTERIM SESSION OF THE AMERICAN MEDICAL ASSOCIATION

The 1950 interim session of the American Medical Association was held at Cleveland, December 5-8th, 1950, and while unfavorable weather lowered the attendance from the expected number, there was great interest in the scientific program and exhibits especially arranged for the general practitioner. Discussions were held on cancer, heart and blood vessel diseases, diabetes, diseases of children, surgery, anesthesia and poliomyelitis.

One hundred ninety-five of the eligible 198 delegates in the House of Delegates were present at the opening session and testified to the interest of the constituent associations in the affairs of medicine. Among the actions of the House were the creation of a section on military medicine, adoption of a report that state blood bank committees be developed in each state to fully cooperate with all other agencies in blood procurement programs, selecting Dr. Dean Sherwood Luce of Canton, Massachusetts, to receive the 1950 General Practitioner's Award, approval of the action of the Board of Trustees in appropriating $500,000 from the educational fund for aid and support of medical schools which are in need of additional financing, recommended full support of the Student American Medical Association, granted budget increases to various councils for furtherance of their activities, again approved an independent Federal agency to control all medical activities except the military and disapproved a proposed plan to place non-service connected veteran cases in civilian hospitals. Full reports of the actions of the House of Delegates appeared in The Journal of the American Medical Association for December 23rd, 1950 and following.

EDITORIAL COMMENT

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BY-LAWS OF THE ARKANSAS MEDICAL SOCIETY

As recommended by the Council and approved by the House of Delegates at the 1950 Annual Session, the following amendments to the Society Constitution and By-Laws will be acted upon at the 1951 Annual Session of this Society:

"Resolved, that Article XI of the Society Constitution be amended to read as follows:

"Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates, but shall not exceed the sum of $25.00 per capita per annum, except on four-fifths vote of the Delegates present; provided, that membership in this Society shall be restricted to those who possess the qualifications set forth in Article IV and who pay the annual dues of the American Medical Association in addition to dues to their component and state society. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Finance Committee before action is taken thereon.

"Resolved, that Section 2, Chapter VII, of the Society By-Laws be amended to read as follows:

"Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual written report of his work, and of the condition of the profession of each county in his district at the Annual Session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed on a properly itemized statement; but this shall not be construed to include his expenses in attending the Annual Session of the Society. A Vice-Councilor for each district shall be chosen at the same time and in the same manner as the Councilors are selected. The duties of the Vice-Councilors shall be to assist the Councilors in the performance of their duty, to act in their stead at all meetings in the absence of the Councilor, to attend meetings of the Council and to vote in the absence of the Councilor, provided that the Vice-Councilor shall have the privilege of the floor at all meetings."

RANDOM THOUGHTS OF THE SECRETARY

January 6th. Sponsored by Meschan we strive to meet with nonchalance the blase senior class this morning and trust that we may have imparted a bit of worthwhile information which warrants their early appearance to hear our talk on the function of roentgenology in medicine.

January 13th. Again speaking to the senior class on the application of roentgenology to the practice of medicine, an assignment which we find certainly refreshes our personal knowledge. Our trip down to Little Rock this week-end is another in those hectic travel problems which attend our wanderings, the night plane passing by Little Rock, we board the Rock Island at Booneville, sleep into Little Rock and up belatedly and away to the school and, weather persisting unfavorable for air travel, we take the bus home, having the opportunity to assay relative merits of train and motor coach travel and we wonder if either form would be interested in our testimony.

January 18th. Back and forth on Highway 71 this afternoon listening to several radio performers receive the award of "Honorary Citizen of Idaho" from the Governor, this being Idaho Potato and Onion Week, causing us to wonder how Hoyt Wooley and Executive Secretary Bird could have overlooked our personal qualifications for this honor, having traversed Payette National Forest, the Middle Fork of the Salmon with its tributaries: Elk, Half Moon, Pistol and other creeks, slept on the good Idaho ground, ascended its peaks and gave it our blessing as a great State with wonderful people.

January 18th. Taking off from the Fort Smith airport we step into our room at the Albert Pike in Little Rock just sixty minutes later, something of a time record even for these fast days. So down to visit with Pete Deisch where the conversation ranges among such diverse subjects as legislative ramifications, the Black Hills of South Dakota, the scope of roentgenology as a medical science, the Denver conference and medical care as it is practiced in the army.

January 20th. By the airliner this morning to arrive some thirty minutes late necessitating working through what was to have been a leisurely lunch and an afternoon "OFF" is partly expended in catching up with things which should have been done some days ago.

STATE OF ARKANSAS
Executive Department
PROCLAMATION

WHEREAS, our State and Nation owe a great debt to those unselfish physicians who labor long hours to care for our sick and who are constantly engaged in research to prevent human misery and suffering, and

WHEREAS, it is fit that we should from time to time pay tribute to those unselfish individuals who guard the health of our Nation,

NOW, THEREFORE I, Sid McMath, Governor of the State of Arkansas, do hereby proclaim Thursday, March 30, 1951, as

DOCTORS DAY

and do call upon all the citizens of Arkansas to remember their physicians on that day and in some way express their appreciation to these guardians of the Nation's health.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arkansas. Done in office at Little Rock, this 22nd day of March, 1950.

(Seal) SID McMATH, Governor.

C. G. HALL, Secretary of State.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE physician in general practice, the health officer, the public health nurse, the tuberculosis worker, the patient's family, and, in fact, the whole community has a stake in solving the problems presented by the tuberculous patient who walks out of the hospital against medical advice. What makes him such a difficult problem? We know that the emotional and mental virtues and vices found among the tuberculous are found equally among any other cross-section of the population.

WHY DO PATIENTS GO AWOL?

The behavior of the tuberculous patient may be ascribed to three factors (1) what he is inherently as a personality, (2) the effects of the disease upon him individually, and (3) his capacity for enduring the ordeal that everyone knows hospitalization for tuberculosis to be.

The tuberculosis mortality rate in this country has declined dramatically, and tuberculosis is no longer the great killer it once was. New skills have kept alive many of those patients for whom tuberculosis was once fatal. Yet, for the year 1947, tuberculosis was still the first cause of death from disease in the age group 15 to 34 years. Tuberculosis is still a dreaded disease that terrifies those whom it afflicts. A recent study describes the "psychological black-out" that occurs when the diagnosis of tuberculosis is made known to an individual.

There are other diseases which, like tuberculosis, require long-term hospitalization. There are contagious diseases other than tuberculosis which demand isolation and separation from family. Other diseases have no specific speedy cure. Prolonged bed rest with physical, emotional, and mental relaxation, a negation of normal human tendencies, may be prescribed for patients of various types, including the tuberculous. However, few of man's ills can equal tuberculosis in the degree to which it combines all these devastating characteristics, creating a personal, psychological, and social burden for the individual that is too often overwhelming without outside help and support.

The disease is burden enough. So, too, is the cure. The tuberculous patient must enter an alien environment which separates him from his family and friends. Here he will be reminded daily that he is different, that he cannot have the intimacy and contact with his loved ones that other sick persons may enjoy. He will be expected, for many hours a day, to perform a feat difficult even for the well—to relax physically, emotionally, even mentally. He will have adequate "leisure for brooding." He feels the element of shame and failure that still surrounds tuberculosis. He will be plagued by fear, the one emotion almost universally found among the tuberculous. Fear of the consequences of the disease, fear of the loss of standing and prestige in the family, in the community, in the economic world, fear of surgery, fear of death—these are the attitudes commonly found among the tuberculous.

The tuberculous patient is a difficult problem because his own problem is difficult. His inner resentment will soon express itself in hostility to the attendants, the nurses, and the physician. His family and friends also become subjects of suspicion. It is then that he asks himself—Why tolerate it longer? You can rest at hame, why not get out? The family needs your help anyhow with domestic and economic problems. You're not making any headway here; you're just another case of tuberculosis. They don't understand. The patient complains about the food, about the lack of attention, about the staff's indifference. He will not take his rest, delights in breaking rules. Finally, he quits and walks out against medical advice. His act is a rebellion against himself and against the authority sanatorium life represents. He must rebel or explode.

Not all tuberculous patients react this way. Those who have internal strengths, or who receive from others the psychological and social supports that hospitalization demands, can pull through and use sanatorium life as an opportunity

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Solution is vaporized in wash bottle and carried to operative site and by condensation assists in maintaining a sterile field.

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Stainless Steel	$11.50
Bottle and clamp extra	9.50
Rubber Pressure Tubing (We recommend 7 ft. at $.20 per foot)	1.40
PENBERTHY Aspirator	3.75
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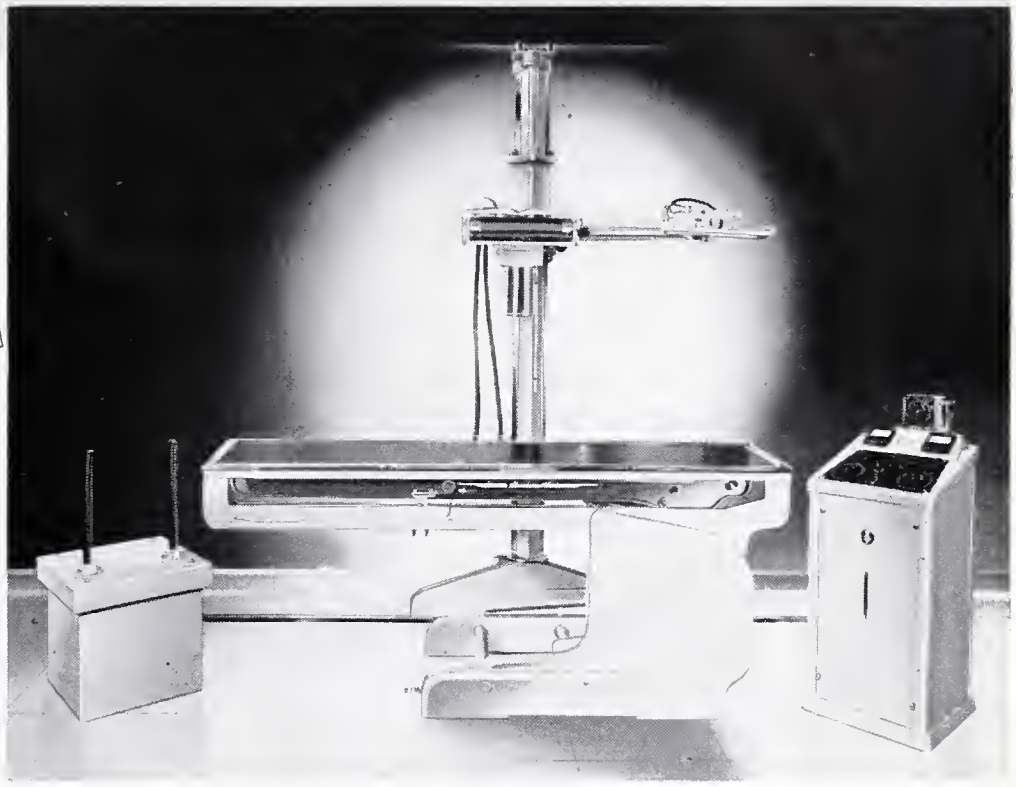


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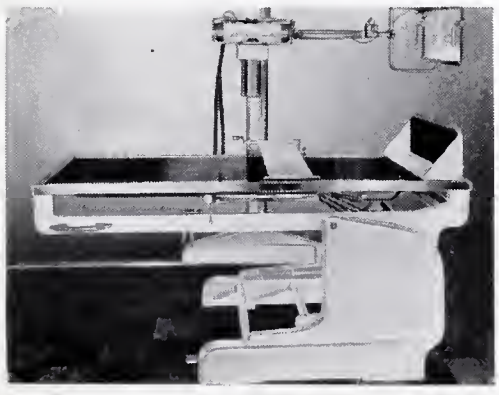
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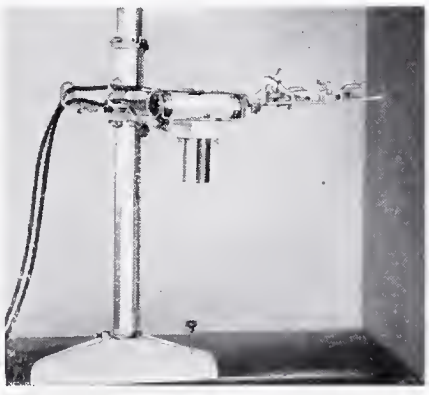
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to plan for a constructive post-hospital career.

Many patients need help. This is attested by the fact that failure of hospitalization, reflected in discharge against medical advice, is found in tuberculosis to a degree unparalleled by any other disease. There may be some who are beyond help. It is difficult to penetrate an embittered outlook or chronic alcoholism that is well aged by the years. For a few, compulsory hospitalization seems the only solution. However, there are more positive and more helpful measures which should be explored before the resort to force.

As a minimum, the tuberculosis patient needs emotional and psychological preparation for hospitalization. No one can do this better than the physician. If, at the time of diagnosis, he takes the time to explain the disease and its impact upon the life of the patient and his family, if he expresses interest in the personal and social problems that hospitalization creates and can give the patient assurance and encouragement, the physician will have made a wise and humane investment of energy and effort.

The public health nurse, during her visits to the family, can do much to fortify the patient for the difficult experience ahead. The role of the emotions in tuberculosis and the damage that can be wrought by worry and anxiety should be frankly discussed with the patient by both the physician and nurse. The function of the social worker should be explained and referral to the appropriate social agency should be made where necessary.

In the hospital, a comprehensive treatment program must be followed, introduced by a period of orientation in which the patient is an understanding participant. This means a concern not only for the physical manifestations of tuberculosis, but for the emotional and mental balance of the patient and his outlook for the future.

It is presupposed that the staff will have been taught the emotional and psycohological components of illness, of long-term illness in general, and of tuberculosis in particular. In their daily contacts with patients, the staff will be sympathetic and understanding, respecting the patient's integrity, treating him as a mature adult, by their manner and attitudes helping to reinforce him so that the difficult task he faces will be made easier.

Social service should be made available to help the patient with problems that may otherwise rob his energies, retard his recovery, and lead him to reject the hospital. An active rehabilitation program will help the patient to begin planning for a meaningful life ahead.

There is no easy, magic way. The recalcitrant tuberculosis patient is a serious problem for society because his disease is a serious problem for him. To the extent that the psychological and social supports are provided, the problem becomes an easier one for the patient and for everyone concerned.

Why Do Patients Go AWOL? William B. Tollen, Ph.D., NTA Bull., July, 1950.

OBITUARY

TOM MABRY, age 70, Holland, died May 30th, 1950, from coronary artery disease. Born in the Happy Hollow community, he graduated from the University of Arkansas School of Medicine in 1906 and had practiced continuously in Faulkner county. A member of the Faulkner County Medical Society, he had served in its various offices during his years of membership. He was a member of the Methodist church and of the Masonic bodies. He served throughout World War II as a member of the Faulkner County Selective Service Board. Surviving relatives are his wife, three sisters and a brother.

CHARLES CLAY REED, age 42 years, died at Little Rock January 5th after a long illness. He had practiced in Little Rock since his graduation from the University of Arkansas School of Medicine in 1933, being associated with his father, the late C. C. Reed, Sr., until his death. During World War II he served with the army medical corps. He was a member of the First Methodist church, of the Masonic bodies and Scimitar Shrine, a Fellow of the American Medical Association, the American College of Surgeons and the International College of Surgeons and assistant professor of surgery in the University of Arkansas School of Medicine. Surviving relatives are his wife, a son and a daughter.

J. S. COFFMAN, age 71 years, Lavaca, died December 30th, 1950. A graduate of the College of Physicians and Surgeons, Little Rock, in 1907, he had practiced at Lavaca for 43 years. He was a director of the Bank of Lavaca, a former member of the school board and had been active in many civic organizations.

CYRUS R. GRAY, age 67, Newport, died January 5th of heart disease. Born in Independence County, June 13, 1883, he graduated from the University of Tennessee College of Medicine in 1908 and began practice at Newport in 1911 after first locating at Sidney, Arkansas. He es-

tablished his first sanitarium at Newport in 1918 and opened a new hospital building in 1940. He was a member of the First Methodist church and of its board of stewards, of the Masonic bodies and of the Jackson County and Arkansas state medical societies and was a Fellow of the American Medical Association. Surviving relatives are his wife, two daughters and a son.

HUGH JOHNSON, age 72, Fort Smith, died January 14th of heart disease. Born in Polk County, Arkansas, he graduated from the University of Arkansas School of Medicine in 1906 and had practiced continuously in Fort Smith since graduation. He was a past-president of the Sebastian County Medical Society, a former member of the executive staff of Saint Edwards Mercy Hospital, county coroner of Sebastian County for over forty years, a member of the Masonic bodies, the Kiwanis Club and a deacon in the First Baptist church. Surviving relatives are his wife, two daughters and a brother, Dr. J. E. Johnson, Fort Smith.

BONNY M. STEVENSON, age 70, Camden, died June 3rd, 1950, after an illness of several months. A graduate of the University of Nashville Medical Department in 1908 he engaged in private practice at Crawfords before entering public health service. Prior to assuming directorship of the health unit at Camden, he had served at West Memphis. He was a former vice-president of the Arkansas Medical Society and of the West Memphis Rotary Club, a member and steward of the West Memphis Methodist church and a member of the Camden Rotary Club. Surviving are his wife and a daughter.

BOOK REVIEW

Methods in Medicine: By George R. Herrmann, M. D., Ph.D., Professor of Medicine, University of Texas Medical Branch at Galveston; Director of the Cardiovascular Service and Heart Station, University of Texas Hospitals. Consultant in Medicine to the Surgeon General, U. S. Army; Consultant in Vascular Diseases to the Marine Hospital, U. S. P. H. S., Pp. 488. Price, $7.50. Second Edition, Completely Revised. The C. V. Mosby Company, St. Louis, 1950.

First revision since 1925 of the Manual of the Medical Service by George Dock. The manual has been planned as a practical ward or bedside guide. There are well presented sections on laboratory procedures and on dietetic methods. The remainder of the book is devoted to methods of clinical investigation of all disorders—by systems or diseases—which suggests steps in diagnosis, tests and their interpretation, etc. The intern, the resident, and the practitioner will find this volume helpful in solving his diagnostic and therapeutic problems.

PROCEEDINGS OF SOCIETIES

Garland County Medical Society met at Hot Springs December 9th with the following scientific program: "Sarciodosis," Augustus Davison, United States Army, Hot Springs.

The following 1951 officers were elected: President, H. King Wade, Jr.; Vice President, R. L. Daniel; Secretary-Treasurer, Paul H. Woods; Delegates, Lon Reed, E. R. Browning and J. L. Rosensweig; Alternates, Jack Wright, Loren Bohnen and Warren Chamberlain, all of Hot Springs.

Crawford County Medical Society met at Van Buren December 19th, electing the following 1951 officers: President, G. K. Patton; Vice President, S. D. Kirkland, both of Van Buren; Secretary, R. L. Brier, Mulberry; Delegate, O. J. Kirksey, Mulberry and Alternate, S. D. Kirkland.

Bradley County Medical Society has elected the following 1951 officers: President, W. B. Reasons, Hermitage; Vice President, Merl T. Crow; Secretary-Treasurer, W. J. Hunt, both of Warren; Delegate, W. J. Hunt and Alternate, R. E. Greene, Warren.

Little River County Medical Society has elected the following 1951 officers: President, W. H. Daubs, Foreman; Vice President, J. G. Shelton, Jr., and Secretary, Norman Peacock, both of Ashdown; Delegate, J. G. Shelton, Jr. and Alternate, Norman Peacock.

Searcy County Medical Society elected the following 1951 officers: President, J. O. Cotton, Leslie; Vice President, P. L. Evans and Secretary, W. T. Moore, both of Marshall; Delegate, P. L. Evans and Alternate, Sam G. Daniel, Marshall.

Ouachita County Medical Society has elected the following 1951 officers: President, John H. Miller; Vice President, Tom Meek; Secretary, R. B. Robins; Delegate, James Guthrie and Alternate, John L. Dedman, all of Camden.

Ouachita County Medical Society met at Camden January 4th with the following scientific program: "Lesions of the Colon," L. P. Good, Texarkana.

Mississippi County Medical Society has elected the following 1951 officers: President, Louis F. Hubener; Vice President, B. F. Scott, both of Blytheville; Secretary-Treasurer, C. W. Silverblatt, Osceola; Delegate, L. D. Massey, Osceola;

Alternate, Eldon Fairley, Wilson; Censor, L. L. Hubener and Program Chairman, Jack Webb, both of Blytheville.

Craighead-Poinsett County Medical Society met at Jonesboro January 3rd and W. E. Berry, Jonesboro, outlined requirements for registration of physicians under Selective Service on January 15th.

The following 1951 officers were elected: President, A. C. Modelevsky; Vice President, Malcolm O. Peeler and Censor, M. E. Blanton, all of Jonesboro.

Lawrence County Medical Society has elected the following officers for 1951: President, E. J. Cruse, Black Rock; Vice President, J. B. Kirkley, Imboden; Secretary-Treasurer, Chas. D. Tibbels, Black Rock; Delegate, J. B. Elders and Alternate, J. B. Kirkley.

The Association of Tumor Clinic Staff Members in Arkansas met at Little Rock January 25th for the following program: "Various Applications of Radioisotopes to Medicine," I. Meschan, Little Rock; "Cancer of the Oral Cavity," E. Sugarbaker, Jefferson City, and "The Cancer Control Program of the American College of Surgeons," W. E. Batchelder, Chicago.

The Pulaski County Medical Society was addressed January 8th by W. A. Reilly on "The Use of Radioactive Iodine in the Treatment of Thyroid Disease."

E. F. Gray, Secretary.

Announcement is made of the Third Annual Neuropsychiatric Meeting to be held at the Veterans Administration Hospital, North Little Rock, March 1st and 2nd, 1951. Speakers will include Harold G. Wolf, New York; Jules H. Masserman, Chicago; Edwin F. Gildea, St. Louis; Harvey J. Thompkins, Washington; Edward D. Greenwood, Topeka, and there will be professional exhibits and clinical demonstrations. Interested professional personnel will be welcomed subject only to the limitations of seating facilities. Further information may be obtained by writing the hospital.

WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary to the Pulaski County Medical Society will meet at the Y. W. C. A. on January 17, 1951, with Mrs. T. D. Brown, President, officiating. Luncheon will be at 12:00 o'clock. Mr. Glen Walther will speak on the present Legislative Program, "A Timely Phase."

Mrs. A. Kahn, Jr.,
Publicity Secretary.

The Pope-Yell County Medical Auxiliary met Thursday evening, January 11, in the home of Mrs. Max Mobley for its regular meeting. Mrs. William O. Young presided over the business meeting. It was voted that we send color books, crayons and scissors to the Arkansas Crippled Children's Home in Little Rock as our project for February. No further business, the meeting adjourned.

Mrs. Max Mobley, Reporter.

The Woman's Auxiliary to the Jefferson County Medical Society met at the Pine Bluff Country Club, Friday, January 5. After luncheon, Mrs. Howard S. Stern presided over the business meeting. Tentative plans were laid for the Annual Davis Hospital Benefit Style Show to be held February 17, the proceeds from which are to establish a Davis Hospital Charity Fund for indigent patients. Mrs. Charles W. Reid, Public Relations Chairman, announced there will be a second series of thirteen Health programs broadcast weekly over a local radio station. Mrs. Fred Hames, Nurse Recruitment Chairman, announced the Auxiliary and the Jefferson County Nurses' Association will co-sponsor a Nurse Recruitment Program at the Senior High School on Thursday, February 22, at 7 p. m. Mrs. C. B. Hockaday, President of the State Nurses' Association, will be speaker for the occasion.

Mrs. T. J. Cunningham, Jr.,
Publicity Chairman.

The Woman's Auxiliary to the Sebastian County Medical Society met at the McCartney House, Fort Smith, on January 8th, with Mrs. Robert Thompson and Mrs. James Hodges as hostesses.

Mrs. W. L. Shippey, President, presided, appointing the Nominating Committee, consisting of Mrs. Kenneth Thompson, Mrs. Ralph Crigler and Mrs. S. J. Wolferman. Mrs. M. E. Foster, Program Chairman, introduced Mrs. Fred Krock, who presented the new Constitution and By-Laws.

Mrs. E. C. Moulton, Jr.,
Publicity Chairman.

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THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

RESOLUTION

WHEREAS, an all-wise providence has seen fit to remove from our midst, Dr. W. R. Richardson, who was our valued co-worked and a faithful member of the Pulaski County Medical Society since April 5, 1939, we the members of the society mourn and deeply regret his sudden departure.

He was the son of the distinguished Rev. William Reed Richardson.

WHEREAS, as a physician in his chosen field of surgery, he attained a great measure of distinction and won the respect of his colleagues, as well as, the gratitude and love of a host of sorrowing people. He studied medicine at Vanderbilt University in 1921 and began practice in Little Rock in 1923.

WHEREFORE, BE IT RESOLVED, that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of the Society and its heartfelt sympathy to the family at the untimely loss that they have sustained.

BE IT FURTHER RESOLVED, that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy sent to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee.—Fred Wm. Harris, M. D.

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The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Vol. XLVII FORT SMITH, ARKANSAS, MARCH, 1951 No. 10

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(1) Ravdin, I. S., and Gimbel, N. S.: Protein Metabolism in Surgical Patients, J.A.M.A., 144:979 (Nov. 18) 1950.

(2) Vars, H. M., and Gurd, F. N.: Role of Dietary Protein in Experimental Liver Regeneration in Nitrogen Balance Study, Am. J. Physiol., 151:391 (Dec.) 1947.

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THE MEANING OF MODERN PATHOLOGY TO THE GENERAL PRACTITIONER *

A. NETTLESHIP, M. D.
Little Rock

May I, at this time, express my gratitude for the opportunity to speak before this society. Such an honor can only be interpreted as a sign of your wish to give recognition to one of the branches of primary medical science. For such recognition I give sincere thanks.

Before launching into the formal aspects of this speech, may I tell about a recent movie short which I saw of the late Doctor William H. Welch. As all of you know, it was he who brought to the shores of this country the continental scientific methods which brought about the revolution in American medicine which is still going on today. In watching this movie short which was made in 1930, on Welch's 80th birthday, it was impossible not to be struck by the tremendous advances about which he spoke, those in the fields of bacteriology, pathology, endocrinology, and even a preshadowing of the antibiotic era. The movie made me realize what was known by 1930 and enforced upon my attention the well nigh unbelievable era 1930-1950. We may well ask what next?

With so much of our time being spent upon fighting socialized medicine and worrying over the economic aspects of medicine, it is a pleasant surprise to find each of you still so intensely interested in scientific medicine. It is true that the field of medicine has long been attractive financially and because it assures good social status. However, these aside, each of you practices medicine and continues in your love of your work because of the problems which the field continually poses. It is about these scientific problems which I wish to talk briefly today.

All branches of medicine work for a common goal which is a solution to the causes, nature, prevention, and cure of diseases. These objectives are immediately and daily yours; they will surely remain the ultimate attainments of all medical investigation. Since this is true, it is not unique for pathology, an investigative science, to take its proper place in the continuing assault upon disease. What this aspect of pathology means to the general practitioner is that medical science, and consequently medical practice, shall continue to advance only so long as those of us who are in the laboratory can devote our time to the more intimate study of bodily structure and functions, along with our colleagues at the bedside. So long as you assure us this freedom, with sufficient opportunities and compensations, there need be little worry about continued advance in medical practice.

It is said, "A disregard of our forefathers is an actual courting of oblivion for ourselves." So, let us review some of the happenings in this rapidly changing era of medical progress. There came about a slow realization that there are specific living agents which produce diseases, bacteria. Working out the relations of these isolatable agents to the diseases which they produce gave us the bacteriological era. During this time and immediately following, we also came upon a fuller knowledge of the endocrine and nutritional disorders, the former either a lack of or excess of secretions, the latter usually deprivation diseases. This era is being followed by a hectic antibiotic one which is imperceptible blending into a new era of understanding about geriatrics, heart disease, cancer, to say nothing of tremendous psychiatric advances. This latter is a definite move into the realm of complex home and sociologic problems, those serious unsolved arenas whose products are related to many diseases.

The present very impressive era of application of fundamental research to the welfare of the patient was made possible only through the combined efforts of the earlier pathologists, biochemists, physiologists, and clinicians.

Let us review briefly the pathologist's role in this effort. The practice of medicine revolves first about a correct diagnosis. As you know the clinicians of the 1850's to 1900's spent a

* Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 18, 1950.

great deal of their time correlating what happened in the clinic with what they saw at the autopsy table. This is, as it should be, still a popular exercise. Among these may be listed such names as Hodgkin, Corrigan, Flint, Bright, and later the American Osler and many others. Along with this clinical development came the development of pathology concepts by men like Rokitansky and Virchow. The pathologist began to understand diseases from the gross and microscopic standpoint, and began to speak of inflammation and degeneration, and in the latter part of the 1870's, of functional pathology and experimental pathology. One of Welch's papers of this time treats extensively of adaptation. We then began to understand both acute and chronic inflammation. The pathology of thrombosis and embolism was also worked out by Welch, and the "Ghon" tubercle was described as late as 1912.

From the pathologist's understanding of neoplasms, all modern cancer therapy is based. The pathology of cardiac anomalies has been worked out, as well as the pathology of coronary sclerosis and myocardial infarction. The latter has been carefully correlated with electrocardiographic changes. Much of this, as well as the knowledge concerning cancer, has come through the fields of experimental pathology. Most recently, pathologists have given carefully descriptive expression to the lesions resulting from malnutrition, specifically those of vitamin deficiency and other deficiencies. The lesions of the endocrine system have been carefully described. Lesions of virus diseases are being worked out. This broad classification of recent work in pathology may make it sound as though the job in the field of pathology is finished. This is far from true. For example, new diseases appear continuously and it is the part of the pathologist to discover and classify such diseases. It is also his role to rework the fields of a disease which has already been described and about which we think we understand a great deal. A prime example of this is the three diseases which were completely reworked from the standpoint of the pathologist, and of which we have a much better understanding, during the second world war. I am speaking of influenza, or as we call it atypical pneumonia, "shock", or lower nephron nephrosis as we call it, and "epidemic hepatitis". As you know, war gained material has allowed us new and extensive insight into each of these.

The pathologist must keep continually abreast of the times, because he must use his knowledge of disease to further the concepts and point with caution to the use of new discoveries. Many of the antibiotics have not come to us as unmixed blessings. The pathologist long ago said that sulfa drugs at times produce myocarditis and marked destruction of the kidneys. The pathologist's continuing knowledge must be that of discovery, classification and aid to the clinician.

The definition of a pathologist may first be stated by telling what he is not. He is not a glorified technician, neither is he solely a "laboratory man". He is an M.D., a physician, just as you are. He is not merely a physician. He is a physician who has added to his clinical medicine many years of hard study and close observation of human disease.

Many of you may wonder just what function the pathologist fulfills, just where he does fit into the medicine of today. We may say that traditionally the pathologist has always played the role of attempting to help his practicing colleague by adequately explaining the mechanism of disease processes. The pathologist still does this, and it is likely that he will continue with his traditional role for many years to come. If this is the pathologist's role, how is it fulfilled? This may be answered by familiarizing you with some of the work we are doing at present in the department of pathology at the University.

Let us list the functions of the pathology department:

1. Teaching of students, interns, residents, staff, and general practitioners.

2. Service function, autopsies, surgical pathology, medico-legal work.

3. Research on cancer and the ageing processes.

Perhaps the single most important aspect of the pathologist's work is his effort to bring to the clinician fruits of the pathologist's current thoughts. Contacts with clinical, biopsy, experimental, and autopsy work placed in conjunction with current literature make for a product both alive and useful to the clinician. The modern pathologist is no longer a "dead house" dweller but rather a functional pathologist whose suggestions are practical and useful in the betterment of the patient's welfare. Any pathologist, whether he be practitioner or teacher should be recognized for this value above all others. The pathologist forms a solid rod of orientation thrust into the swirl of clinical practice.

We, then, in the department of pathology serve a primary learning and teaching function whether to students, interns, residents, general practitioner, or specialist. And, lest this be

looked upon as a bootless recitation of textbooks, let me say that, at present, preparation of any formal lecture in the department takes between 20 to 40 hours of reading and reference work. In contrast to the older courses given in pathology our most effective teaching, however, takes place in small group discussions which are completely frank and open. In these group discussions the only authority is observable fact itself. The climax of the teaching week at the University Medical School and Hospital is the Thursday afternoon Clinical Pathological Conference. Here the essence of all clinical practice is distilled against the discernible facts of the autopsy. An integral part of the teaching method is the careful, exhaustive post mortem examination. It is clear that the scientific level of a medical society may be gauged by the number of autopsies done upon fatal cases. No physician is capable of medical practice for long without confusion. To the physician with scientific spirit and the desire to learn the autopsy is necessary and unless the physician is willing to test diagnostic and treatment skill against autopsy knowledge he will be a poor practitioner. Every autopsy teaches something. The pathologist must perform the autopsy with skill and make careful scientific inquiry into the patient's clinical history. From the abnormal morbid anatomical conditions, the pathologist thinks in terms of altered function and clinical manifestations. He then interprets and acts as consultant to the clinician. In so doing, he must state his case in clearly understandable terms. The days of pathological mumbo-jumbo and mystery are past. Many of you are situated where a competent pathologist is available and the situation for those of you who are not is getting steadily better. The physician devoted to patients and profession cannot do a proper job unless he tries to secure autopsy on every patient who dies.

The department of pathology fulfills a large service function in the state by performing autopsies, medico-legal work, and surgical pathology examinations. The medico-legal work is badly needed and no other agency in the state has equipment or personnel trained for this work. The surgical pathology examinations have been done in the past for any physician who cares to submit material. The policy of the University has been to encourage this work for any indigent patient. We leave it up to the physician who sends the material to determine whether the patient is indigent. The department would encourage any physician who seeks consultation on difficult surgical pathological cases. We now have personnel well trained in this most difficult of all pathological arts.

If your school of medicine is to become well medical intellectual life revolves, research must recognized and serve as a center about which be done in the school. The need for this has long been recognized and at least partially met. The department of pathology does cooperative research with departments within the school and with any physician or agency outside the school who desires to work in the department. Much of this investigative work is case study and report work, some of it is so-called pure research. Within the department, our primary investigative functions are those of finding out what we can about the various diseases we find at biopsy and autopsy. In addition to this, there are two well defined lines of investigation under way — research on cancer and research on the ageing processes. Our cancer research has been upon the earliest discernible stages of cancer. The question we have asked ourselves is, what happens at the precise moment cancer starts? Clinical—pathological studies on human cancer have given us a partial answer to this question and we have work in publication on this aspect of the problem. To get nearer the answer we have been doing experimental work with methylcholanthrene in hamsters. I have just returned from a National Society meeting where this latter work was presented and discussed. In summary, it is sufficient to say that within twenty-four hours after the carcinogen has been applied, we can recognize those cells whose descendents will be frank cancer. You may see the practical importance of such a study from the standpoint of early diagnosis and treatment. Our research work on the ageing process has lagged due to the lack of adequate facilities and help.

I hope this brief review of what we are trying to do in the department of pathology has given you some insight into how the present day pathologist is related to the general practitioner. We are not school-book scientists, but, rather physicians who are additionally trained in one field, the field of pathology; with all of the implications this bears. Our function is a very practical one, helping the general practitioner practice better medicine. Better medicine will be practiced in this state only if you physicians give all pathologists in the state your unqualified support. Unless this is done, the entire meaning of pathology as an integrative, interpretative science of medicine, utilizing basic science in the diagnosis and treatment of disease shall be lost.

STATE HOSPITAL PROBLEMS IN THE MIDWEST *

E. ROGERS SMITH, M. D.
Indianapolis

It seems to me, and the thought may emanate from the mind of a poor, tired, old neurologist that psychiatry is being asked to do too much. In recent years, probably partially because of our own efforts and partially because of the war, we have become too much in demand. The world has become too conscious of psychiatry and there are, of course, not enough of us in neuropsychiatry to do all the jobs that are being wished upon us. There are times when I resent the burden that is being forced upon us, and which we are apparently willing to assume. Not only during the war did we do most of the screening and eliminating of the unfit in the armed forces, but now that the world has been saved, we are expected to keep it safe for the Democrats. Not only to the laity but to many of us in the medical profession, psychiatry is being considered the answer for every problem. In a way it is rather pleasant to realize how important we are, how capable and competent the entire human race apparently thinks us to be. There are other times when it is rather appealing to think of being a surgeon or a gynecologist and not feel called upon to do so much for the human race. Saving the human race is at times not always a pleasant chore.

In contrast to the above thought, I wish to suggest another chore that should be undertaken by the neuropsychiatrists and physicians, particularly those not in institutional or state work. All of us know only too well the sad conditions in most of our state mental institutions, although all is not as bad as portrayed in the movies. I have a very personal knowledge of those in my own state, and through the aid of some of our members I have reports on the conditions of the mental health problems in many of the other central states. For over 30 years from 1897 to 1932 the mental institutions in Indiana were relatively free from politics. This was brought about originally by a group of men who demanded, and later enforced, the edict that all the personnel of the institutions caring for the mentally sick were not to be considered as political plums or footballs. This took the concerted and earnest effort of a large group of humane and public spirited citizens. This satisfactory condition prevailed until about 17 years ago. At that time it changed suddenly and the new era of the political selection of personnel came into vogue. Then came the famous "2% club" of Indiana and as Senator Jim Watson said, "If you can't whip 'em you'd better join 'em," and in 1932 in Indiana, you joined 'em if you were in a state job. The same club returned to Indiana in 1949. I'm glad to say that so far we have not as yet reached the depths of some of the other states where the famous old double play team of "Tinker-to Evers-to Chance" or the more modern version "precinct committeeman-to ward healer-to patronage board" is necessary for state hospital employment.

During the World War period, Dr. Larue D. Carter, Head of the Department of Neuropsychiatry of Indiana University, aided by some of the other members in Indiana, decided that the successful crusade of fifty years ago to take the institutions out of politics, should be renewed. As a result of this effort of the neuropsychiatrists not employed in institutions and of a group of interested lay persons, a good law creating a Council for Mental Health was enacted by the legislature of 1945. This law and the resulting Council for Mental Health were ably supported and helped by the State Government of that period, and were given most favorable publicity by the press. The care of all the mentally ill in the state was placed in the hands of this group of appointed men, one neuropsychiatrist, one general practitioner, the head of the State Public Health Department, also a doctor, one Circuit Court Judge, and the head of the Public Welfare, who is not a doctor. Money in sufficient amounts was allotted, building plans, rather extensive, were made and Indiana seemed well on its way to good care for the mentally ill.

In Indiana the merit system holds for all personnel except the superintendent and chief clerk. However in the minds of the medical personnel, we have found always the fear of political removal. At the beginning of the recent change in administration, the Mental Health Council was beseiged with questions from the State Hospital Superintendents, and from the personnel directors, for some reassurance that there would not be the almost complete turnover in the personnel that had occurred in 1932. The personnel board endeavored to point out that the employees were under the merit system but no statement confirming this was forthcoming from the executive branch of the government. Consequently, many key men resigned feeling that

* Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 18, 1950.

they could better themselves in other types of employment.

The attendants and nurses are, as you know, in closer contact with the patients and consequently, are the most important and largest group in the hospital. To them we must offer security and the certainty of continuous employment. We need to remove the fear of political amputation from them in order to encourage them to seek careers in our institutions. In regard to the medical officers, we have been faced with the difficulty in hiring them from other states in spite of the fact that the salaries in Indiana compare favorably with those of other states, and with the Veterans Administration. Many hesitate to accept appointment when they know that there is the possibility of removal from their jobs during a political turnover or because of some whim of the State's Executive. Other states, such as Minnesota, Kentucky and your own state, have similar satisfactory plans. The State Government in Minnesota is particularly interested in better psychiatric care and is turning to the non-institutional psychiatrist and the members of the medical school for aid in decisions and the outlining of policies. In any state much depends on the controlling board of directors and one politically minded member can overcome the plans and hopes of the majority.

On the other hand, one of our neighboring states seems to be more politically minded than even we Hoosiers, who are politicians from birth. Its personnel are not always hired because of what they know—but whom they know in their political party—and, apparently, the plan of employment requires that all personnel even to the lowest must get the approval of the local patronage board before they can even appear before the state patronage board. As you can easily see, so much time is consumed in this political screening that many applicants find employment in other fields. As a result the personnel who are hired after this long period of waiting, are often not of the caliber that we would seek or hope to secure. Although the executive head in this state is openly in favor of good and not necessarily politically minded personnel for his state institutions, practical politicians of lesser rank will not permit him to carry out his plans and hopes. Being a big politician with an eye to his career, he must listen to and follow the demands of the lesser lights who have done so much to place him where he is today. Too often we find that men who have been elected to high political positions, have made promises and incurred personnel debts that they cannot ignore once they are in office or when they are seeking even higher offices.

I am indebted to Doctor George Fletcher and to the last issue of your State Medical Journal for my knowledge of your plans for the care of the mentally ill of your state, and I feel that your plans are excellent, and that you are fortunate for your executive branch of government's cooperation and psychiatric understanding. This latter is necessary and important for the success of any plan in any state.

Most planning groups cannot help but fear that too much is expected too rapidly—that the changes for betterment which they hope for in years to come are expected by the public in the very near future. As we have obtained sufficient funds, and as we build larger and more modern hospitals, the friendly press blare our success. The public is then led to believe that the entire problem is solved. Then there is the danger of the loss of public interest. They do not see our problem of proper and adequate personnel—of training and teaching. They do not know our fear of larger, beautiful buildings partially staffed becoming too soon not treatment centers or screening hospitals, but domiciliary homes and magnificent detention wards.

Have any of you ever tried to argue with a chronic constitutional politician? Did you ever gain much of a constructive nature? Easily they pass out smiles, promises or pats on the back. Remember you are just one individual—or at best a small group of spook specialists to be laughed off by the politicians. You are trying to take their living away from them—and what do you know about practical politics? Individually, or in small groups, you are butting your head against a bulkhead. Nothing but a mass reaction and a noisy one will budge them—and then possibly only temporarily. We must let the press and the voters know the facts of life in the institutions and get them to carry the ball. As long as any State Executive or his political bosses has the power to hire and fire one single employee caring for the mentally ill, the other employees of all levels will lack in security. Politics in state institutions is more dangerous than gasoline and whisky—far more so. That governors should support such an attitude is incomprehensible, inexcusable and disgusting. The public—the voters—must be told that political domination of the mental health problems will defeat

the most carefully planned and financially secure program.

And now to revert to the additional burden that I wish to add to your medical shoulders. I'm afraid that all of you will feel (and I must agree) that most of my criticism is destructive and not constructive. But how can I—or anyone offer our mentally ill—or the men that care for them, any panacea? How can any remedy or battle plan be composed to combat that serious group of little thinkers—the politicians, the predatory—self-perpetuating group that in so many states control the care and health of our mentally ill? As individuals or as a group there is so little we can do. It takes numbers, public thought, interest, voices, even money, to make these men see what we need and must have. All medical men in practice, in the universities, must strive to get our institutions for the mentally sick out of politics. The physicians in the State Hospitals cannot do it. In addition, too long the medical profession and the teachers in the universities have looked upon the hospital physicians as professionally unfit. Most of the universities and the medical schools have been very careful not to be contaminated by any association with the State Hospitals. So far the medical schools in the country have done little or nothing to elevate the standards of the State Hospitals. At the same time, the medical schools and universities have overlooked a very worthwhile field to cultivate. In the State Hospitals, there is a wealth of material to be studied and worked with. This does not refer merely to the psychiatric but to the neurological, surgical and medical. Where else is there such a wealth of pathology present and under control for long time study. The pathologist has been and is interested. Physiologist, biochemist and nutritionist have shown little interest.

Those in the hospitals and in the appointed councils are so bound and tied that they can seldom express their views. One word or one act can easily eliminate them or veto any thoughts of progress. What are the reasons? Probably the main reason is that in this democracy of ours, in spite of all protestations to the contrary, legislation has been mainly by pressure groups. The pressure group of our medical university alumni has not been vociferous. The universities should, under no circumstances, take over the control of the State Institutions but should use the facilities of these hospitals for teaching. The students and residents of the medical schools would thereby obtain first hand information of the enormous problems of chronic mental illness.

As I have said, all this is a renewal of an old crusade. To me it was more than interesting to discover among my father's records a letter written 52 years ago by a wonderful Quaker gentleman, Timothy Nicholson, who was for years the head of the State Board of Charities in Indiana. Mr. Nicholson's whole life was devoted to humanity—in the largest and fullest sense. This letter was in answer to one from Dr. Joseph G. Rogers, Superintendent of the Northern Indiana Hospital, and later president of the American Psychiatric Association. Dr. Rogers was deploring the fact that the efforts of the Superintendents for better and more intelligent care of the mentally sick were being contested and ignored by the Legislature then in session.

Part of this letter is as follows: "Thy message of yesterday is very disheartening to me. I beg thee not to give up the fight although such a request may seem strange from one of my faith. We must all unite and prevent at all cost the members of the General Assembly from doing the unfair acts they contemplate. They must know that our unfortunate charges in the Asylums are still human beings and not pawns on the political board. As we grow older we find lobbying more distasteful, but thee must not fail thy less fortunate brethren."

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MAJOR TRIGEMINAL NEURALGIA (TIC DOULOUREUX)

ROBERT WATSON, M. D.
Little Rock

The persistent appearance of aged people suffering with long standing and uncontrolled face pain, justifies a short discussion of the subject of major trigeminal neuralgia, commonly referred to as tic douloureux.

The diagnosis of major trigeminal neuralgia, or tic douloureux, is easily made in the typical patient. This is a disease of middle and late life. It has such a fixed pattern that if the patient is permitted to give the doctor an uninterrupted, spontaneous relation of the symptomatology, there is little probability of an incorrect diagnosis.

The patient complains of face pain, limited to one side of the face, originating in the same locality each time, and always radiating in the same direction. The patient who uses the whole hand to indicate vague generalized face pain over a wide distribution is not a patient with tic douloureux. A tic patient points toward the site of his pain. One fingertip is usually sufficient. He or she hesitates to actually touch the sensitive area for fear of bringing about a recurrence of pain.

Tic pain is not a generalized prolonged type of pain. Instead, it is characterized by sharp, short, stabbing, or electric-like radiating pains of the face that are definitely intermittent in character. A tic patient is apprehensive always of a possible recurrence of this pain. Sometimes in the course of an ordinary conversation, he will suddenly tilt his head forward slightly, stop the conversation instantaneously, and cup his hand before one side of the face as if to form a protective shield. The whole of the facial masculature of the affected side becomes tightly contracted. The eye is tightly closed. Tears may run down that side of the face. He may remain taut, speechless and motionless for a matter of ten to thirty seconds, following which he will relax, slowly regaining his normal posture and emotional control, withdraw his hand from his face and sit in an upright position. Usually within a minute of the sudden interruption of the conversation, the patient will again continue in his speech. Within a few moments he will state that he is again without pain. During these intervals of remission. there is no abnormal sensation of the face; nor is there any abnormality of facial musculature or expression, except that a patient, between attacks, seems to limit slightly the motion of the affected side of the face for fear that abnormal muscle contraction will again bring about pain.

These patients may have been suffering with this pain, at intervals, for periods of possibly only a few months to periods of many years. Recently, one man of seventy-nine years dated the duration of his pain from its onset thirty-three years previously. It is probable that many of these patients will state that early in the disease the pains were not of great severity, and it is observed that sometimes only following a recurrence of an attack will the patient recall the initial one. At first these attacks of face pain may be relatively mild and infrequent, occurring at intervals possibly several months apart; but during a period of years they may become so increased in both intensity and frequency, that the pains occur in an almost endless chain for days, later entering into a period of remission for days to weeks.

Other patients, however, have experienced severe and frequent pains from the initial onset. Bearing in mind that these attacks are subject to spontaneous remission, one can well understand that a change of medication, timed with a spontaneous remission of symptoms, would result in a false evaluation of the treatment used at that particular time.

It is also characteristic of the disease that stimuli to certain areas of the face or gums may initiate an attack. (Other attacks seemingly come on spontaneously.) These so-called "trigger zones," the seat from which stimulation is likely to bring about pain, are commonly found along the nasolabial fold of the cheek, or along the gum line of the upper or lower canine teeth, or along the lower angle of the mouth, or down the medial and inferior portion of the skin overlying the chin. Trigger zones around the eye-lid or forehead are uncommon. The trigger zone is usually a single location. Seldom do trigger zones exist over both the upper and lower lip. However, initial pain may spread as far from the upper lip as to involve the areas of the lower lip and the forehead.

The unkempt appearance of the skin over some specific area of the face will oftentimes indicate that this is the trigger zone. It is because of these trigger zones that the patient is kept always on the alert, apprehensive and fearful that some unsuspected stimulus may initiate an uncontrollable spasm of face pain. In time the patient begins to live in fear of numerous stimuli —washing the face, shaving, chewing, swallowing, or even a draft of air—all or any of which might initiate an attack. It is not uncommon to see a patient with many days' accumulation of dirt and

debris over one side of the face because he knows that cleansing the face will likely bring about the pain. Also, because of the fear of pain these patients undergo severe nutritional damages, for they know that chewing or swallowing may initiate the pain.

It is unfortunate that some of these patients have been told that little could be done for their pain. No hope was offered some of these people and they were told instead that they would have to learn to live with the pain. Through the same ignorance, other patients have been told that if the nerve is cut the face will be paralyzed; that likely they will lose the sight of the eye on the side of the operation, and that probably after all it would be better to endure the pain. It is a well known fact that patients with trigeminal neuralgia will go to any measure to be relieved of pain; therefore, some patients will be encountered who have run the gauntlet of all manner of conceivable therapy. The majority have had repeated dental extractions until all teeth have been sacrificed. These procedures, naturally being of no value, have possibly been followed by repeated scrapings of the bone, which, too, is of no avail. Fortunately, such a quality of attempted treatment is rapidly disappearing.

The treatment of tic douloureux has now become completely standardized. It divides itself into two proven satisfactory measures: alcohol injection, and surgical section of the sensory nerve root. Alcohol injection offers a satisfactory temporary means of alleviation of pain. At times there are definite indications for injecting the peripheral branches or the ganglion with alcohol. However, both the patient and the one making the injection must bear in mind that an alcohol injection does not offer a permanent and everlasting relief. It must be borne in mind that the effects are temporary. A successful injection may give total relief of symptoms for a period of from six to eighteen months, or, rarely, even longer; but the patient must be made to understand that in time these symptoms will recur, that the results of a second injection will not be as satisfactory as the initial one, and that during this interval the patient is aging and becoming a less favorable risk for surgery.

Section of the sensory root of the trigeminal nerve is the accepted method for producing permanent relief of pain. It is unquestionable but that this relief of pain is complete. However, the patient is penalized for relief from this pain: The price that the patient must pay for the complete relief of pain is anesthesia of the areas from which the pain originated.

The patient must be made well aware of the consequences of the section of these sensory fibers. As the result of surgery, a portion of one side of the face becomes anesthetic. Although this anesthesia is permanent, the awareness of it on the part of the patient and its associated annoyance is transitory. Time brings about a satisfactory adjustment on the part of the patient to this numbness.

The trigeminal nerve is primarily a nerve of sensation, possessing only a few motor fibers which supply the masseter and pterygoid muscles used in the process of chewing. Rarely these motor fibers are damaged at surgery, but if such is the case, the results are in no way disastrous, in that the patient will oftentimes tell the surgeon that for years he had been fearful of chewing on the affected side of his face and that from habit he has always chewed on the other side. Therefore, this weakness in chewing on the side of the operation is of no great consequence to the patient. One of the common complaints from the patient following surgery is that food becomes lost between the gum margin and the cheek on the side where the operation was done. Others say that for a brief interval there is sometimes a tendency (because of the anesthesia existing) to unknowingly bite the mucus membrane of the affected cheek while chewing.

Inasmuch as the trigger zones are primarily in the second and third divisions, rather than in the ophthalmic nerve distribution, rarely have unfortunate results occurred even though it was necessary to section the whole nerve.

Every patient who undergoes surgery enters into an irreversible bargain. He exchanges his face pain for loss of sensation over the previously painful area for the remainder of his life. This is a most welcome exchange on the part of the majority of patients, however, about two per cent of those who undergo surgery are later so annoyed and discomforted by the numbness or paresthesias of the face, that to them the price they pay for this exchange to rid them of their pain becomes quite high. Unfortunately, some of these patients possess a fleeting memory, and following surgery forget their previous face pain, becoming annoyed, instead, to almost the same disturbing degree, by the paresthesias which sometimes exist. These people are usually of a worrying, emotionally unstable type, to such extent that in retrospect the surgeon should have singled them out as potentially discontented patients. Although it would be impossible to resuture the nerve, the offer to do this on the part of the surgeon, bringing the patient back to the previous preoperative state will usually

silence all complaints. When the patient is presented with the possibility of trading back the newly acquired numbness for the old tic pain that he once had, the numbness is always the choice.

It must be remembered that facial neuralgia is not a fatal disease, but grave nutritional disturbances may result from inadequate intake of nourishment due to the pain and indirectly lead to secondary complicating illnesses and potential death.

The operative mortality in this disease compares favorably with that of any major operative task. Over eighty-five per cent of the patients who are operated on for trigeminal neuralgia are over sixty years of age. Up to the present time the ages of the patients on whom the writer has performed this 5th nerve section have ranged from thirty-six to eighty-six at the time of operation. The operative mortality in experienced hands is less than one per cent. Bearing in mind the advanced age of the average tic patient and all the possible complications that accompany advanced years—such as hypertension, arteriosclerosis, myocardial or renal disease—this gratifying figure justifies serious suggestion of surgery to all patients suffering from major trigeminal neuralgia.

The surgical approach is made through a small cranial opening. The temporal lobe of the cerebral hemisphere is elevated to expose the site for the section of the nerve root. The procedure is an intra-cranial operation but it does not involve the risk of many other types of brain surgery. The hospital stay postoperatively for these patients is shorter than that of the average major surgical procedure, but it hardly justifies such inquiries as, "Will you just clip the nerve at your office?"



CASE REPORT FROM THE UNIVERSITY OF ARKANSAS SCHOOL OF MEDICINE AND UNIVERSITY HOSPITAL

Clinical Pathologic Conference

ANDERSON NETTLESHIP, M. D., Editor

Case Number: 2343 Unit Number 80682

Summary of Clinical History

Chief Complaint: Unable to walk, duration two and one-half months.

Present Illness: Patient stated that she was fairly well up until four months ago at which time she began to have pain in her knees. About this time she also began to have numbness around her knees which gradually extended toward the ankles. Her legs gradually became weak. For the past two and one-half months, she had been unable to stand on her legs and had been confined to bed. Any weight on feet caused severe pain in her knees, legs and feet. She stated that her legs felt colder than the rest of her body. Patient gave a history of taking Vitamin B, yeast tablets and of eating quite a large amount of raw liver in the immediate past. She had had no edema.

Past History: No serious illnesses. No children, 2 miscarriages.

Family History: No family history of tuberculosis, diabetes, cancer, lues or insanity.

Physical Examination: Patient is a 58-year-old white female, well developed, fairly well nourished appearing older than stated age and appearing chronically ill. Blood pressure 110/50. Pulse 72. Respiration 20. Temperature 98.6. Skin negative. Eyes, ears, nose, and throat: Tonsils slightly enlarged, pharynx slightly hyperemic, no teeth, atrophy of papillae of tongue especially at its margin was noted. Neck negative. Heart: Rhythm regular, no enlargement, no murmurs. Lungs: Clear. Abdomen: No masses or organs palpated. Back: One examiner noted marked tenderness in left costal-vertebral angle. Pelvic and rectal: Negative except for slight discharge, foul odor. Extremities: Moderate atrophy and weakness in both lower extremities, more pronounced in left leg; moderate impairment to light touch and pinprick in both legs; extreme pain on light touch to soles of feet; slight tenderness of calf muscles. Reflexes: Slightly hyperactive bilaterally; no pathological reflexes.

Laboratory Tests:

Wassermann—negative.

Urinalysis—specific gravity 1.029, microscopic—negative, albumin—negative.

Complete Blood Count:

Hemoglobin	Red Blood Cells	White Blood Cells
73%	2.10	9,900
80%	3.25	6,250

Differential Count:

Basophiles	Eosinophiles	Myeloblasts	Juveniles
0	1	0	0
0	3	0	0

Stabs	Polymorphonuclear leucocytes
1	49
0	58

Lymphocytes	Monocytes
45	4
30	9

Hematocrit	Volume Index
28	1.4

Color Index

1.7 using 4.5 red blood cells and 42 hematocrit as normal.

1.23

Reticulocyte count 0.0%; red blood cells measured 8.4 units.

5 degrees free acid present at 45 minutes on analysis.

Gastro-Intestinal Series: Questionable rigidity of the pre-pyloric portion of the pyloric antrum, done in recumbent position. No definite findings, no definite filling defect or ulcer niche could be detected.

Bone Marrow Examination. The bone marrow is normoblastic in type, no definitely abnormal nucleated red blood cells are seen, no cell seen of megaloblastic cells.

Course in Hospital:

The patient was admitted on 7-31. She was given, on 8-6, Folvite (folic acid) 5 mg. twice daily. It was planned to give this for four days and then start liver extract but on 8-8 patient's temperature rose to 101° and she suddenly expired at 5:52 a. m.

Case Presentation by Dr. S. T. W. Cull

I would like to waste a few minutes and impose upon your patience by restating what was said to you at the opening of the year about the purpose and function of the clinical pathological conferences. The conferences are not a feat of intellectual pugilism nor are they a question of being right or wrong. The physician's only right by accident or wrong by accident. If I may illustrate, when the data is inadequate or inaccurate the whole case falls. On the other hand, no matter how good the data, if the clinical reasoning is poor, again, it falls. Our purpose is to teach people what sort of data should be obtained on a case before it is presented and to demonstrate logical reasoning based on that data.

The clinical history in this case is an academic scandal. It is hard to see how a history could be so distorted, so inadequate. Let us discuss the diagnosis by headings.

Chief Complaint: This is the history of a 50-year-old white woman whose chief complaint was inability to walk. This history was for a period of two and one-half months.

Present Illness: The patient states that she walked well until four months ago. We know from the chief complaint that after about two months of illness she was totally unable to walk. Her first symptoms were those of pain in the knees, and numbness followed by pain. The legs began to ache. During the last two months she has been unable to stand on her legs and has been confined to bed. She states that she was unable to bear any weight on her legs or feet due to the pain which it caused. So apparently we have parasthesia and muscular weakness brought on by pressure. There is no history of edema. She has been eating large amounts of raw liver in the immediate past and has been taking some vitamin B1.

Past History: We find no serious illness in her past history and though she had two miscarriages, she has had no living children.

Family History: It is unfortunate that this family history is so vague that it gives us no help. We suspect the patient of having pernicious anemia. It has been shown many years ago that pernicious anemia is sometimes a familial disease.

Physical Examination. She is well developed, fairly well nourished. This later is an interesting finding since she is obviously a very ill woman. Addison made the point of how well nourished patients with pernicious anemia usually are. She did appear chronically ill. It is stated that the skin is negative, I doubt this. We would like to know whether this had any peculiar color in the skin. Certainly a positive or negative statement of skin color should be made. There is nothing said of ataxia, so we must assume that the simple tests for ataxia were probably not carried out. Again the history is inadequate because it does not tell us concerning the reflexes. It states that they were slightly hyperactive but does not say whether they were deep reflexes or cutaneous or whether or not there was actually any muscle weakness. There is no statement of parasthesia, although it says there was extreme pain on light touch to the soles of the feet. This is some evidence of hypothesia dolorosa. The rectal and pelvic examinations were in normal range. The heart and lung examinations were normal. No masses were palpated in the abdomen.

Laboratory Examination: This patient showed a marked increase in the number of lymphocytes and platelets. Complete blood count done on the day of her admission showed 73% hemoglobin, 210 red blood cells, 9,900 white blood cells with 49 lymphocytes, 45 polynuclear series and 4 monocytes. The hematocrit reading was 28, volume index 1.4, color index 1.7. The same relationship was found four days later. The color index had dropped to 1.23 and the reticulocyte count was given as 9%, the size of the red cells was measured at 8.4 microns. On the same day they found 5 degrees of free hydrochloric acid at 45 minutes following histamine infection. At this time her hemoglobin had jumped very remarkably. I understand the patient had been transfused so I am at a loss to understand the marked discrepancy in hemoglobin findings. The nurse's note says that she had a diarrhea. This may mean that the patient became dehydrated. The important thing about the size of this patient's red blood cells is the distribution of the cell size. This is extremely important diagnostically. Any case of pernicious anemia may show extreme macrocytic distribution in the blood. It is difficult to understand the 5 degrees of free acid although a small percentage of cases with pernicious anemia have free acid. What we would like to know is what the bone marrow shows. If the marrow was normoblastic, we would like to know the distribution of normoblasts. We would like to know the distribution of white cells in the marrow as well as the red cells. For as far as pernicious anemia is concerned, the white cell pattern is almost as characteristic as the red cell pattern.

Course in Hospital: The sixth day after admission this patient was given folic acid, 5 mg. twice a day. At this time she also had a bone marrow examination which the examiner said showed normoblastic type but no definitely abnormal nucleated red cells, or megaloblastic cells. It is amazing that this patient could have been in the hospital 6 days before she received folic acid. A patient in this condition is certainly a medical emergency. The woman died suddenly yet she had received practically no therapy for her pernicious anemia. I understand the biochemistry department was running some excretion tests on this woman. We have no right to jeopardize a patient's life for the sake of curiosity. As sick as she apparently was, the diagnosis being what it was, she was certainly entitled to massive doses of liver extract. If the diagnosis was wrong, liver extract would not hurt her. It is commonly found that a patient with pernicious anemia may die suddenly and it is often not the one with the lowest blood count.

We have a woman wtih a profound macrocytic hyperchromic anemia who has neurological signs confined to the lower extremities. If a patient has severe anemia and neurological signs, one immediately thinks of a picture of pernicious anemia with combined sclerosis of the spinal cord. This patient's symptoms, though poorly recorded, seem to fit the picture. Although the motor columns in many cases may be little involved, there may be ataxia. You get every sort of combination of posterior and anterial lateral involvement. Most of them have peripheral nerve involvement. To find muscular atrophy in a case of pernicious anemia is rare. To have such pain in the lower extremities as this woman complained of is rare. These findings give us a little pause. We discuss further and see the free hydrochloric acid in her stomach and are aware that a little over 90 per cent of all cases of pernicious anemia have no free acid. There is a good deal of evidence which piles up against pernicious anemia as the diagnosis in this case. The finding in the bone marrow should clinch the diagnosis. Unfortunately for our diagnosis she has been eating liver in large amounts. We should find out what the marrow shows before giving liver, otherwise the picture may become so distorted as to make it impossible for diagnosis.

X-Ray Findings: There is a statement made in the record that there is a questionable rigidity of the prepyloric portion of the pyloric antrum. The plates were done in a recumbent position. It is difficult to be certain about this. There could be rigidity of the gastric wall or antrum due to infiltration by carcinoma or by things other than carcinoma. Unfortunately some of these cases of carcinoma of the stomach may respond for a time to liver therapy. The X-ray examination also showed that they could not examine for a rugal pattern. They did not find a filling defect or ulceration.

As you know, in pernicious anemia you can have complete atrophy of the gastric mucosa or a hypertrophic gastritis. There are certain instances where it may be difficult for anyone, even the pathologist, to say whether it is carcinoma of the stomach with a blood picture of pernicious anemia or true pernicious anemia. It would be nice to have a gastroscopic.

We are going to say definitely that this patient is an atypical case of pernicious anemia and that the neurological signs are atypical. This seems to us the most likely diagnosis and

the bone marrow finding is probably suffering distortion due to the large amounts of liver fed the patient prior to entrance in the hospital. We must put down as a second choice, of course, carcinoma of the stomach.

Final Clinical Diagnoses:

True pernicious anemia with somewhat atypical findings and atypical neurological signs.

Pathologic Diagnosis:

Macrocytic hyperchronic anemia with hyperplastic bone marrow and hypertrophic gastritis. Double pelvis and ureter, left kidney. Emaciation.

Pathologist: Although it is not mentioned clinically, this patient had the curious yellow color of the skin often associated with pernicious anemia. She had no teeth. There was evidence of passive congestion of the viscera and the bone marrow was gelatinous, grey-red in color. A gross examination of the brain showed atrophy of the gyrae with a moderate amount of sclerosis in the larger vessels.

Microscopic: The muscle fibers showed definite, though moderate hyperthrophy. The lungs, edema. The stomach showed a tremendous hypertrophic gastritis with heavy lymphocytis cell infiltration. The bone marrow was typical of that we find in pernicious anemia, it was hyperplastic and filled with many maturing red cells. The spinal cord changes were not distinctive.

Clinician: I would like to ask Dr. Cull how he feels about transfusions in these cases?

Dr. Cull: I would say that depends upon the judgment of the clinician in assessing the general physical status of the patient. In many instances it is entirely warranted to tranfuse these patients while you are trying to get sufficient liver extract into them to get the bone marrow regeneration started. The myocardial findings are interesting since it is a well known fact that if the patient has no treatment, the patient will die from myocardial failure. The hypertrophic gastritis is also very interesting since a small percentage of cases have this instead of the atrophic. It is too bad we have no peripheral nerve sections because these might have shown extensive involvement. Although the neurological picture was highly atypical and although there was free acid in the stomach, I guess we made a lucky guess in calling this pernicious anemia.

Last year the Kansas City Southwest Clinical Society established a fund for a Merit Award for graduates in medicine serving residencies or internships in approved hospitals in this area. Each year the contest is limited to residents and/or interns on duty in a hospital of Arkansas, Colorado, Iowa, Kansas, Missouri, Nebraska, or Oklahoma.

Awards will be given for the three best papers submitted. Each paper must represent original work by the essayist. This work may be a review of clinical cases in the hospital or actual experimental work in the laboratory in which the contestant is serving a residency of internship.

The winner of the first award will receive $500 and will be a guest speaker before the General Assembly of Physicians at the Annual Fall Clinical Conference of this society, presenting his winning thesis. The winners of the second and third awards will receive $100 and $50, respectively.

In order to participate in this contest, applications must be made in writing with the endorsement of the chairman of the Resident-Intern committee or the superintendent of the hospital and mailed to the executive office of the society, address above, by April 15, 1951.

Papers will be accepted for this contest up to and including August 1, 1951.



OBITUARY

ARTHUR KEACH WAYMAN, age 70 years, Little Rock, died February 6, 1951. Born in Brownstown, Indiana, he graduated from the University of Arkansas School of Medicine in 1905 and had continuously practiced in Little Rock. He was formerly house physician for the City Hospital and from 1941 to 1948 was superintendent of the Pulaski County Hospital. A member of the Pulaski Heights Christian church and of the Masonic lodge, he was a life member of the Pulaski County Medical Society and of the Arkansas Medical Society. Surviving relatives are his wife, two sons and a daughter.

JOHN G. WATKINS, age 71, Little Rock, died December 27th, 1950. Born at Mount Ida, August 15, 1879, he graduated from the University of Arkansas School of Medicine in 1903, and had practiced his specialty of eye, ear, nose and throat in Little Rock since that date. He was associate professor of surgery in ear, nose and throat at the University of Arkansas School of Medicine and a staff member of Saint Vincent's Infirmary and of the Baptist State Hospital. In addition to his membership in the county and state medical societies, he was a member of the First Methodist church, the Masonic bodies and Scimitar Shrine temple. He is survived by two sons, Dr. J. G. Watkins, Jr., Little Rock, and Dr. Charles J. Watkins, Saint Louis and two daughters.

JASPER T. MATTHEWS, age 66, Heber Springs, died February 4th. Born in Stone County, he graduated from the University of Arkansas School of Medicine in 1912 and except for time spent in the army medical corps during World War I, had practiced at Heber Springs since graduation. He built the Estelle Hospital there and operated it until a few years ago. He remained in the medical corps of the Arkansas National Guard until about ten years ago. Surviving relatives are his wife, a son and a daughter.

BUCK C. CLARK, age 67 years, Lake Village, died January 13, 1951, after an illness of three months. Born in Macon, Mississippi, he graduated from the Medical College of Alabama in 1911 and practiced at Laurel, Mississippi, before coming to Arkansas. He was a member and chairman of the board of deacons of the Baptist church, president since 1932 of the Bank of Lake Village, chairman of the Southeast Arkansas Drainage Board, member of the Masonic bodies and of the Shrine and of the Lake Village Chamber of Commerce. He was a past-president of the Southeast Arkansas Medical Society. He is survived by his wife.

HERBERT MOULTON, age 90 years, Fort Smith, died January 23rd, 1951, after a prolonged illness which forced his retirement several years ago. A graduate of Illinois College and of the Medical Department of Northwestern University, he practiced at Stuart, Iowa, before locating at Fort Smith in 1890. He was active in medical organizations, serving as president of the Arkansas Medical Society in 1924-25; as chief of staff of Sparks Memorial Hospital for many years; in the various offices of the Sebastian County Medical Society, and was a fellow of the American College of Surgeons, of the American Academy of Ophthalmology and Otolaryngology, the American Medical Association and the International Congress of Ophthalmology. He was a diplomate of the American Board of Ophthalmology and a member of the Southern Medical Association. Surviving relatives are his wife, a daughter, Mrs. S. J. Wolfermann and a son, Dr. E. C. Moulton.

E. T. WILLIAMS, age 70 years, Greenbrier, died January 29, 1951. A graduate of the University of Arkansas School of Medicine in 1910 and had practiced at Greenbrier since graduation. He was noted for his interest in baseball and was voted the "Number One Sand Lot Baseball Friend of the United States" in 1941. He is survived by his wife, three sons and a daughter.

MILTON L. SMITH, age 68 years, Crossett, died December 5th, 1950. Born in Dallas county, he served on the staff of the Crossett Hospital for nearly forty years. Until his retirement he had engaged in private practice. Surviving relatives are his wife, a son and a daughter.

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W. R. BROOKSHER, M. D., Editor
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EDITORIAL

THE ANNUAL SESSION

The Arkansas Medical Society will meet in annual session at the Hotel Marion, Little Rock, April 23rd, 24th and 25th, 1951. The completed scientific program is printed in this issue. The Committee on Scientific Work has arranged scientific presentations which should be of value and interest to all members. The 1951 session is being held at the Hotel Marion in order that meetings could be held on Monday, Tuesday and Wednesday, an arrangement which has not been possible at the Robinson Memorial Auditorium. Space for commercial and scientific exhibits will be curtailed under these circumstances but all other facilities of the session should proceed in a satisfactory manner. The desirability of early hotel reservations is suggested.

CLINICO-PATHOLOGICAL CONFERENCES

With this issue The Journal begins a new feature which it is felt will be of interest to members of the Society. Case reports from the Clinical Pathological Conferences of the University of Arkansas School of Medicine will appear monthly provided these prove of interest to readers. The Journal will be pleased to have comments on this innovation.

THE FIGHT IS NOT WON

W. J. BUTT, M. D.
Fayetteville

During recent weeks, since the November elections, the demise of the 81st Congress and the advent of the 82nd Congress, we of the Medical profession have, to some extent, been basking in the gratification of having fought a good fight and winning it—so far. And we did fight a good fight; and we have won—so far. But it is urgent that we not relax into the fat and lazy ways of peace, or we will yet lose—and be lost. It is proper that we recall to our minds a number of factors which should never be absent from our thinking and our planning.

Firstly, the battle is not truly won; we have achieved thus far only an advantage for the present. The socialist planners who have been with us for years are still with us—and in powerful places. They seem to be undismayed at their partial repudiation at the polls in November. They still plan and strive to burrow away at the fundamental liberties of Americans. If anyone of us thinks that they will desist, let him be at once undeceived. As long as socialists and socialist leaners are in positions of power in this country, this will go on—sometimes openly as it has been, sometimes more quietly and behind the scenes as it is beginning to be now. They must, in the end, either be victorious or be vanquished. Truly, here "eternal vigilance is the price of liberty."

Secondly, if we doctors think that we alone have achieved our present partial victory against socialism, let us, again, be undeceived. Our present advantage could never have been attained by us alone. Without the active and vigorous help of thousands of groups, clubs, organizations, industries, and individuals, our success thus far against socialization of medicine—and socialization in general—could not have been attained. Let us remember, then, that while we are an independent group of traditionally independent individuals, we are in a larger sense very dependent on others for help, for support, for our very existence as we now exist and work and live.

Thirdly, in spite of steady improvement all along the line, medical care for all the people is still far short of satisfactory, and there are many thousands who are financially not able to enjoy all the advantages offered by modern medicine. It is almost mandatory that we con-

tinue our individual and collective efforts to extend and improve the availability of medical service to all people of all classes.

Fourthly, and possibly most important, the final picture of medical practice will be determined by the people with whom we, as individual doctors, deal in our daily practices. When the time comes that we are too busy or too important to give kindly attention to those who seek our help, when we no longer give personal attention to and consideration of our patient's financial ability, when we begin to practice medicine to make money, when we drift away from our solemn vows as doctors—then are we on the road to our own terrible undoing. But so long as we remember and adhere to our physicians' vows of service first, so long as we practice our profession by the Golden Rule, so long as every doctor does his human best to be fair and honest with all of his patients—just so long will the people, our patients, resist and defeat all efforts at socialization, with its consequent degeneration of medical care and of American freedom.

Let us, then, remember that we cannot rest on our laurels. We must be always vigilant. We must remember our dependence on others. We must constantly strive to improve that which we now have to offer. And we must, above all, so conduct ourselves as individuals in our profession that those we serve will not want, nor tolerate any change to socialism. Doctors can do this if they will—we must do it if we are to retain our professional independence, and the free ways of America.

EDITORIAL COMMENT
REPORTS OF COMMITTEES

In accordance with action of the House of Delegates such committee reports as have been received are printed in this issue of The Journal. No provision is made at the session of the House of Delegates for reading of reports, it being the expressed wish of the House of Delegates that all reports be printed in advance of the session. Delegates and members are reminded to preserve this issue of the Journal which contains the committee reports since no printed committee reports will be available at the annual session.

EDITORIAL COMMENT
PROPOSED AMENDMENTS TO THE CONSTITUTION AND BY-LAWS OF THE ARKANSAS MEDICAL SOCIETY

As recommended by the Council and approved by the House of Delegates at the 1950 Annual Session, the following amendments to the Society Constitution and By-Laws will be acted upon at the 1951 Annual Session of this Society:

"Resolved, that Article XI of the Society Constitution be amended to read as follows:

"Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates, but shall not exceed the sum of $25.00 per capita per annum, except on four-fifths vote of the Delegates present; provided, that membership in this Society shall be restricted to those who possess the qualifications set forth in Article IV and who pay the annual dues of the American Medical Association in addition to dues to their component and state society. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Finance Committee before action is taken thereon.

"Resolved, that Section 2, Chapter VII, of the Society By-Laws be amended to read as follows:

"Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual written report of his work, and of the condition of the profession of each county in his district at the Annual Session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed on a properly itemized statement; but this shall not be construed to include his expenses in attending the Annual Session of the Society. A Vice-Councilor for each district shall be chosen at the same time and in the same manner as the Councilors are selected. The duties of the Vice-Councilors shall be to assist the Councilors in the performance of their duty, to act in their stead at all meetings in the absence of the Councilor, to attend meetings of the Council and to vote in the absence of the Councilor, provided that the Vice-Councilor shall have the privilege of the floor at all meetings."

PERSONALS AND NEWS ITEMS

Ralph Hamilton, West Memphis, was recently named "man of the year" by the West Memphis Chamber of Commerce.

The Arkansas State Practical Nurses Association on January 18th adopted a resolution against enactment of compulsory health insurance or "any system of political medicine designed for national bureaucratic control."

Roy Schirmer, Fort Smith, and Allan G. Cazort, Little Rock, attended the seventh annual meeting of the American Academy of Allergy at New York City February 5-7.

Fred Hames, Pine Bluff, was recently elected Chairman of the Association of Tumor Clinic Staffs in Arkansas.

Among those registered at the Saint Louis session of the American College of Surgeons were: J. J. Monfort, Batesville; M. C. Hawkins, Jr., Searcy; Leo Aday, Gordon Holt, Howard Schwander, H. Fay H. Jones, Harry Hayes, Little Rock; John D. Olson, Fort Smith; A. R. Clowney, J. M. Sheppard, W. S. Riley, J. H. Pinson, El Dorado, and E. J. Stroud, Jonesboro.

"Bronchopulmonary Hypogenssis: Diagnosis in the Living," by I. Meschan and J. D. Calhoun, Little Rock, appeared in the December issue of the Southern Medical Journal.

"The Effect of Age upon Obstetric Complications in Primigravida," by Eva F. Dodge and Willis E. Brown, Little Rock, appeared in the December issue of the Southern Medical Journal.

Hoyt R. Allen, Little Rock, announces the association with him in the practice of proctology of Dr. John Laurens who served a residency at the Ochsner Clinic, New Orleans, and who did special work with Dr. Harry E. Bacon in Philadelphia in proctology. Dr. Laurens served in the naval medical corps during World War II.

M. L. Dalton has been elected a director of the Brinkley Golf Club.

H. T. Smith, McGehee, and D. L. Owens, Harrison, have been elected president-elect and vice-president, respectively, of the Mid-South Postgraduate Medical Assembly.

C. H. Lutterloh, Hot Springs National Park, has joined the staff of the Veterans Hospital, Little Rock, as assistant chief of professional services.

Robert Watson, Little Rock, attended the recent session of the Southern Neurosurgical Society in New Orleans.

A. J. Brizzolara, Little Rock, is doing special work on pathology of the larynx with Chevalier Jackson at Philadelphia.

Born—On February 13th, a daughter, Anne, to Dr. and Mrs. Dale Alford, Little Rock.

Ellery C. Gay, Little Rock, was elected to membership in the American Society of Plastic and Reconstructive Surgery at the recent meeting of that organization in Mexico City.

N. W. Reigler, Little Rock, on service in Korea, has received the Combat Medical Badge and has been recommended for the Bronze Star.

RANDOM THOUGHTS OF THE SECRETARY

January 28th. Meeting with the radiologists and later with the council during this day at Little Rock, the discussions confined to legislative matters, and homeward over highway No. 10, a most deserted thoroughfare this gloomy evening.

February 5th. At tonight's staff meeting Hodges brings us a bit closer to understanding of the problem of erythroblastosis fetalis, a matter not intimately concerned with radiology but one with which we strive to become conversant.

February 7th. With Gross to accompany Goldstein to Poteau where the subject is "Common Skin Diseases," in other words, those skin conditions which Goldstein saw in his office this day, an amazing array of lesions.

February 8th. In company with the Councilor, Fount Richardson, to Rogers for dinner with the Benton County fellows with discussion on legislation and peptic ulcer, a combination which is the usual type of program for medical societies but whether the first leads to the second we do not profess to state.

February 9th. Scanning the legislative scenes with Pete Deisch and it would seem that the pressure groups are not the medical profession as might be the idea from comments in the press.

February 12th. Winter in the old timer manner descends upon Arkansas and we are almost of the mind to remember when the river was frozen but maintain a youthful attitude in refraining from such comment as being within our acquaintance.

February 20th. With Bob Thompson, Amis, Stewart and Whittaker down highway ten tonight, the biggest horse in the state disputing, with startling abruptness, our right to the highway, and we wish the Senate would quit temporizing with that stock law so these Pulaski county animals could have no excuse to plead indecision over application of the law. With hundreds attending the hospital hearing encouraged indeed over the attendance of physicians but keeping our fingers crossed over final disposition of this additional cigarette tax money.

PROCEEDINGS OF SOCIETIES

The Mid-Continent Psychiatric Association will meet at the Hotel President, Kansas City, Missouri, March 31st-April 1st. The profession is cordially invited to attend.

Craighead-Poinsett County Medical Society met at Jonesboro February 7th with the following scientific program: "A Surgeon's Viewpoint of Janudice," C. H. Porter and "An Internist's Viewpoint of Jaundice," Barney Wetherington, both of Memphis.

Columbia County Medical Society met at Magnolia February 15th with the following program: "Contact Dermatitis," Raymond Hughes, Texarkana and "If You Don't Watch Out," Mr. J. T. Book, Arkansas Power & Light Company representative.

Garland County Medical Society met at Hot Springs February 13th with the following scientific program: "Hydro-Therapy," John D. Currence, New York, New York.

The Benton County Medical Society met in dinner session at Rogers February 8th with Chas. F. Bloom discussing the roentgen diagnosis of peptic ulcer.

Lee A. Dean, Secretary.

D. W. Goldstein, Fort Smith, addressed the LeFlore County (Oklahoma) Medical Society at Poteau February 7th on "Common Skin Conditions."

REPORTS OF COMMITTEES

(To be presented to the 1951 session of the House of Delegates, Little Rock, April 23, 1951; published in The Journal in accordance with action of the House of Delegates at its 1948 annual session. These reports will not be read at the annual session but committee chairmen may amend or add to the printed reports.)

SCIENTIFIC EXHIBITS COMMITTEE

JAMES H. GROWDON, Chairman

The scientific exhibits section of the 1951 State Medical Society meeting has been allotted space on the mezzanine floor of the Hotel Marion in Little Rock. There will be room available for approximately twelve exhibits in booths of about 12' x 8' with some additional space for smaller displays not requiring a booth.

The Committee has contacted by letter last year's exhibitors, the presidents of county medical societies, various state and federal agencies and hospitals, clinic groups, and the departments of the medical school, inviting interested parties to participate. At the present time twelve exhibitors have been assured space in the section. The committee will attempt to accommodate any further requests made prior to April 10, 1951. Interested parties are urged to submit their request at the earliest possible date.

The Committee wishes to recommend that in future meetings the scientific exhibits section be allotted space that is in close proximity to the meeting hall and commercial exhibits. Isolation on a different floor of the hotel discourages the interest of the exhibitors and those desiring to view the exhibits.

The provision of booths for exhibitors by the Society is highly commended. The Committee hopes this practice will be continued.

LEGAL AFFAIRS COMMITTEE

W. J. BUTT, Chairman

This Committee has had one formal meeting during the year . . . a joint meeting with the State Board of Examiners and the Council. No independent action was taken by this Committee: its function at that meeting being that of liaison and recommending group between the State Medical Board and the Council of the Society.

There have been no matters of a medico-legal nature referred to this Committee for investigation or action.

There have been no cases of violation of the Medical Practice Act referred to this Committee for investigation or action.

We offer no changes in recommendations submitted in the last previous annual report of the Legal Affairs Committee.

MEDICAL SERVICE COMMITTEE

J. A. HENRY, Chairman

The committee has little to report this year. At the 1950 meeting of the State Medical Society, it endorsed a proposal recommending that legislation be enacted to finance needy medical students and that those receiving aid, return to rural communities having need of a physician.

During the recent Governor campaign, the committee contacted both candidates and attempted to obtain their endorsement of this proposal. Unfortunately, the successful candidate turned down the program; and for this reason, plus the financial condition of the state and the unsettled world condition, this legislation was not placed before the present legislature. It is believed that if conditions should prove to be more opportune in the future that this proposal be placed before the legislature for their consideration.

The Medical Service Committee met with the Military Medicine Committee concerning Civilian Defense, this meeting taking place during the month of December.

The work of this committee is still in a formative stage and we have nothing to report as far as any definite steps that are to be taken. However, this committee stands ready to do all that it can to be of assistance to the State in any civil defense program which will be enacted in the future.

MILITARY MEDICINE COMMITTEE

EWING M. NIXON, Chairman

On May 6, 1950, the Chairman of the Military Medicine Committee attended a meeting at the headquarters of the American Medical Association in Chicago, which was designed to aid the states and territories in their Civilian Defense Planning. This meeting occupied the entire day and was very instructive. In this meeting many civilian defense problems were discussed and it was noted that the state of Maine had made considerable progress towards an active Civilian Defense Program. In addition, many of the chemical and explosive results of atomic weapons were discussed. There was present at this meet-

ing representatives of the American Medical Association, the Health Resources Division of the National Security Resources Board, the United States Veterans Administration, the Atomic Energy Commission, and the Department of Defense. There were present numerous consultants to the American Medical Association and it was at this meeting that Dr. James C. Sargent gave his definition of Civil Defense, which I think is the best yet promulgated. He stated that "Civil Defense, down to its essence, means the organization of the civilian population to minimize the affects of enemy action."

In July, 1950, the Oklahoma State Medical Association in a communication to the Arkansas State Medical Society, called attention to the possibility of a large number of our doctors holding reserve commissions being called into active military service irrespective of their length of previous service. The Council of the Arkansas State Medical Society met on Sunday, July 30, 1950, and it was at this meeting a resolution was enacted which was immediately forwarded to Senators and Representatives requesting that physicians be called for military duty, in the following order, unless they desire immediate active duty:

1. Physicians educated at the expense of the government, who have had no active military service.
2. Physicians trained at their own expense, but deferred from active service to gain their education.
3. Physicians deferred from active service because of minor physicial defects, who were able to carry on private practice during World War II.
4. Veterans of World War I and II in reverse ratio to their length of active service.

Soon after, Congress set forth laws governing the entrance of doctors into military service and the majority of the above recommendations were approved.

In July, 1950, the Governor of the State of Arkansas, had printed a State Civil Defense and Emergency Plan, and later during 1950 Maj. Carl C. Martin was appointed as State Civilian Defense Director, and he in turn appointed Dr. T. T. Ross as Medical Director of the Civilian Defense Program. On December 7, 1950, the Chairman of the Military Medicine Committee met with Drs. Ross and Washburn of the State Health Department, and plans were made for a meeting of the Military Medicine Committee as a whole with Dr. Earle Hunt, President of the Society, Dr. Charles R. Henry, President-Elect of the Society, for a meeting on December 14, 1950, to discuss matters pertaining to the medical aspect of the State Civil Defense Program. As the result of that meeting, a State Civilian Defense Committee of the Arkansas Medical Society was appointed jointly by Drs. Hunt and Henry. This committee is composed of Drs. Peter O. Thomas, Chairman; Benjamin B. Wells, Ewing M. Nixon, Edwin F. Gray, Robert W. Ross and M. J. Kilbury, Sr. It will be noted that this is a small committee, that all members are centrally located, and that they may easily attend called meetings by Dr. Ross, and also represent various specialties concerned in Civilian Defense from a medical standpoint.

In addition, on December 14, 1950, Dr. Ross appointed the Health Resources Committee, which is a large committee and contains representatives from the State Medical Society and allied facilities. This is an extremely large committee and its initial meeting was held January 30, 1951, at the State Board of Health. At that meeting the purposes and plan of the Medical Section of the State Civilian Defense Program were outlined and each department's duties were designated.

The Civilian Defense Committee of the Arkansas Medical Society will have frequent meetings and in conjunction with the University of Arkansas School of Medicine staff, a training program for the doctors of the state is to be instituted for the care of the sick and injured. As far as possible, in these discussions, the treatment of fractures, shock, burns and radiological injuries will be standardized in order that better treatment will be afforded the casualties from such a disaster.

INDUSTRIAL HEALTH COMMITTEE

SAMUEL B. THOMPSON, Chairman

The Committee submits the following recommendations:

(1) That the Committee be enlarged to include an internist, dermatologist, a member of the staff of the State Health Department, two or more general practitioners who are part time industrial physicians (if such are available), surgeon, ophthalmologist and orthopedist. It is also recommended that this personnel be appointed for terms of various lengths, so that some continuity of the work of the Committee may be carried over from year to year.

(2) That each county medical society, where there is a considerable amount of industry, organize a Committee on Industrial Health within the county medical society.

(3) That the State Committee promote the organization of such county committees by such measures as sending speakers to meetings of the councilor district and county medical societies.

(4) That the chairmen of the county committees seek guidance in their tasks from the State Committee.

(5) That liaison be established with the State Industrial Nurses Association and a representative of this group sit with the Committee in its function.

The following objectives for both the State and County Committees is submitted as follows:

(1) To promote awareness by the medical profession, employers, and employees of the value of conserving industrial health.

(2) To promote improved relationships between the medical profession and all agencies, groups or persons interested in industrial health in the State.

(3) To promote professional and lay education in, and adoption of, accepted methods of reducing the frequency and severity of occupationally connected disabilities.

(4) To promote improvements in legislation affecting the health of employed persons.

(5) To work in full cooperation with the Industrial Health Section of the State Department of Health.

The following projects are listed as examples of functions the County Committees might undertake:

(1) Encouragement of small industries to establish wash rooms with hot water.

(2) Provision of reading racks containing health pamphlets at some center where employees congregate in plants.

(3) Encouragement of plants to organize for emergencies or catastrophies with definite plans made for calling of ambulances, and arranging hospital beds, and obtaining medical attention with the greatest efficiency.

(4) Designation of some individual as a first aid man as an additional duty to his regular job, where there is not sufficient personnel to warrant a full time first aid man or plant nurse.

MENTAL HYGIENE COMMITTEE

A. C. KOLB, Chairman

Previous reports of this committee have emphasized the magnitude of the mental health problem in this state. There has been no change from the statistical standpoint in this respect since the last report was presented to this Society at the annual meeting one year ago.

Our State Hospital continues to be overcrowded as are other state hospitals throughout the United States. The only hope for improvement in this particular problem, as well as the over-all problem of the tremendous incidence of mental disorders among the people of this country, is an educational program sponsored by state health departments; by organizations interested in mental hygiene; by adequately trained psychiatric personnel in lectures and talks to student bodies and to the public; by properly prepared articles on mental health for publication in the newspapers over the state and over the signature of the Committee on Mental Hygiene of the Arkansas Medical Society. The latter plan would reach many more people than either of the other plans mentioned but all working in the same direction would accomplish much toward reaching the desired goal.

The distribution of literature in the form of pamphlets on the subject of mental health by the state health department and mental hygiene societies would be another media for disseminating information to the public. The Louisiana Society for Mental Health has prepared a series of pamphlets on "Prevention of Maladjustments." These pamphlets are being distributed in quantities by the State Health Departments of Louisiana, Texas, Oklahoma, New Mexico, Georgia, West Virginia, Delaware and Alaska. These articles are producing satisfactory results.

Many of our most disabling and fatal infectious and contagious diseases have been conquered in the past through the work of our state health departments with the cooperation of our state medical societies. The chief weapon used was education—enlightenment of the people. We are right now witnessing another demonstration of this type of attack on such diseases as tuberculosis, poliomyelitis, cancer and heart disease. Laymen are heading some of these campaigns. At the time this report was being prepared, we witnessed an unusual incident in Arkansas in the interest of conquering just one disease—poliomyelitis. This was the "Mothers' March" in Little Rock and 100 other towns and cities in Arkansas on January 29th when hundreds of women went forth for one hour in sleeting and sub-freezing weather and called on homes at night and solicited funds for the drive against this disease. We never expect to see such a demonstration in the interest of prevention of mental disorders.

Mental illness constitutes the major public health problem in any state. One-half or more of all hospital beds are occupied by mentally sick patients. At least 50% of all patients who go to any doctor's office seeking treatment are suffering from some kind of emotional disturbances. In spite of these facts, the public at large and the medical profession as a whole display but little interest in measures attacking the problem of prevention of these disorders. No concerted effort in the past has been made by the profession to induce the legislature to appropriate sufficient funds for the operation of our State Hospital above the level of custodial care and poor custodial care, at that. The profession has approved the construction of the Medical Center on the State Hospital grounds in Little Rock. This approval has recently been reaffirmed by both the Council of the State Medical Society and the Pulaski County Medical Society. Whether the legislature provides the funds for the construction of the Medical Center or not, we should continue to demand its accomplishment in the interest of the School of Medicine of the University and the public health of the state.

The School of Medicine of the University of Arkansas now has a Department of Psychiatry and Neurology, chief of which is Dr. William G. Reese who will be on a full time basis, and will assume his duties on March 1, 1951. He succeeds the late Dr. Poe who died soon after his appointment last year. Dr. Reese served as Director of Professional Education in the Veterans Administration Hospital at Perry Point, Maryland, prior to his acceptance of the position in the School of Medicine here. Dr. Edmond Erwin, psychologist, will be associated with Dr. Reese in the work of the Department. He, also, will be on a full time basis. The addition of this Department marks a new epoch in the history of the School of Medicine. It means a more intensive training of the medical students in psychiatry and neurology. These subjects are now taught in the four classes. Clinical training is given the students in the mental hygiene clinic which is operated under the jurisdiction of the Department of Psychiatry and Neurology. Play therapy for maladjusted children has also been recently instituted in the mental hygiene clinic.

Psychiatrists and neurologists from the Veterans Administration Hospital in North Little Rock, the State Hospital, the Regional Office in the Federal Building and psychiatrists and neurologists in private practice in Little Rock serve on the teaching staff in the Department of Psychiatry and Neurology and also carry on psychotherapy in the mental hygiene clinic as well as instructing the students in this unit of the Department. This accomplishment has developed out of the "Over-all Community Plan" established two or three years ago by Dr. Harold W. Sterling, Manager of the Veterans Administration Hospital in North Little Rock.

We urge every society member to become more interested in the subject of mental disorders because of the tremendous need for a more concerted support of measures directed toward lowering the incidence of the greatest public health problem in the state.

PUBLIC HEALTH COMMITTEE

E. D. McKNIGHT, Chairman

There has been no smallpox in Arkansas for two years. Universal vaccination as advocated by the health department will assure us that no epidemic of this disease will again occur here. Poliomyelitis was epidemic in 1949 and was prevalent in some sections in 1950. This epidemic disease occurs in cycles. Progress has been made in the last two years in providing more adequate hospitalization for the victims of this disease. The fight on malaria has continued unabated and this disease is no longer the major cause of illness in this state. Vigilance is necessary to see that transmission of this disease is held at a low level. The incidence of typhoid fever has remained low, with only three deaths reported as due to this cause in 1950.

During 1950, through the venereal disease control efforts of the Arkansas State Board of Health, local county health departments and licensed physicians throughout the state, Arkansas has experienced an appreciable decline in its venereal disease rate. At the present time Arkansas is enjoying the lowest venereal disease rate in its history. In 1949 approximately 17,881 cases of all venereal diseases were reported by all reporting sources; in 1950 approximately 12,402 cases were reported. These totals, as compared to the 24,442 cases reported in 1948, are indeed encouraging.

The cooperation of private physicians of the state in the enforcement of the prenatal law which requires that all expectant mothers be examined for syphilis and have a blood test for the disease has been a great aid in further reducing the incidence of congenital syphilis.

The state is badly in need of a pre-marriage physical examination and blood test for syphilis law. We are one of nine remaining states that do not have in effect this

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basic public health law. This law and its enforcement would be an additional aid in still further reducing the over-all state venereal disease rate. We now know that continued application of intense control efforts supplemented with present rapid treatment will one day further reduce the rate to less than twenty cases per annum per 100,000 population, the desired low rate when the venereal diseases will no longer be a public health problem.

In the Division of Maternal and Child Health, the nutrition program has expanded by one-third and the program for vision and hearing testing of school children has tripled since January 1, 1949. Nutrition consultation service has reached 52 counties and hearing or vision programs were added in 29 counties. Pediatric and obstetric consultation service has been established to assist the physicians and public health nurses who gave educational and preventive services to approximately 3,500 mothers and 18,000 children per year in each of the two years. Post-graduate instruction in pediatrics or obstetrics was provided approximately 320 practicing physicians in the state. Scholarships were furnished four nurses for post-graduate training in premature nursing; two for advanced obstetric nursing; one each for training in midwifery and public health nursing. Three other scholarships were granted for courses in public health nutrition, public health education, and vision and hearing testing procedures. Programs for midwife control and for care of premature infants were continued. Health work for children of school age was strengthened. Four summer work conferences for teachers were held and a joint committee with department of education staff established. More than 8,000 school children were given complete series of sodium fluoride treatments for reduction of tooth decay.

The Division of Tuberculosis Control during 1950 has held chest X-ray survey clinics in 530 communities in the state: In these clinics, 186,572 persons were X-rayed, and approximately 650 cases of unsuspected pulmonary tuberculosis were initially discovered in this manner. Approximately 3,000 individuals were referred back to their family physician for the further investigation of chest conditions. It is to be pointed out that approximately 65 types of pathology other than tuberculosis may be revealed by a chest X-ray, and there is actually a greater proportion of non-tuberculous cases discovered than the specific disease for which this program was originally designed.

Intensive, block-by-block X-ray surveys have been conducted in Jefferson, Sebastian, Phillips, Garland, Benton, Poinsett, and Independence Counties. Over fifty percent of the adult population in each of these counties was X-rayed.

The central tuberculosis case register now contains the names of almost 9,000 persons who are either actively ill of tuberculosis or who still require medical supervision. This register, now in its fifth year of operation is beginning to reveal some very interesting facts. It is of interest to note that almost half the persons dying of tuberculosis die in the home. Since these terminal cases are usually highly infectious, a grave potential spread of the disease is thus produced. It should also be noted that only one-fifth of the newly reported cases of tuberculosis are being reported by the practicing physicians. This means that of the approximately 2,000 cases reported for the first time in 1950, only about 400 of these were reported by the family physician, the individual who is primarily charged with the reporting of such cases. One appalling thing is that ten percent or 200 of the new cases reported during the year were first reported by death certificate. This means that these cases ran their course from start to finish without any public health supervision.

The death rate from tuberculosis continues to decline, but the number of newly reported cases still approximates 2,000 a year. With this terrific morbidity the fight is far from won, and the constant awareness of the private practitioner to this pressing problem is urgently needed.

During 1950 services offered by the Division of Industrial Hygiene were provided to approximately 16,500 industrial workers through 148 plant visits to a total of 131 different plants. The basic program continues to be the detection, evaluation elimination of occupation health hazards. The dissemination of basic health information as applied to industry has been stressed through regular articles in the state health bulletin which is made available to all plants. Plant surveys and technical studies, including field determinations and laboratory analyses, continue to be primary functions. In addition, personnel of this division have received basic training in radiological monitoring and health problems arising from research and industrial use of radioactive materials.

During the past fiscal year, the Hygienic Laboratory has performed 286,202 tests on 241,965 specimens. Our clerical division types and checks out approximately 1,000 reports per day. Approximately 300,000 cc of typhoid vaccine for free distribution to the cities and counties has been prepared in the laboratory. This amount of vaccine is sufficient to immunize 120,000 persons and would cost about $15,000 if purchased from commercial manufacturers. The complete laboratory staff consists of twenty-two persons.

In the bureau of sanitary engineering 102 sets of plans and specifications were reviewed and approved for water and sewerage systems and swimming pools or major improvements to existing systems and pools. The cost of these proposed improvements is estimated at $7,242,000. New water and sewer systems and swimming pools and major improvements to existing ones during this period cost approximately $7,226,000. Included in the above improvements and construction were four complete water systems, seven sewage treatment plants and eleven new swimming pools. This department played an active part in bringing about these improvements.

The year 1950 found the food and drug division able to give much better coverage to all of its programs. Two principal factors were responsible for this progress. First, three previous years of experience in carrying on the divisions' work has made us much more familiar with the problems we need to deal with. Second, a better trained staff of sanitarians working out of local health departments has been the other contributing factor.

The food and drug laboratory analyzed a total of 373 samples of food and drugs during the year 1950. Twenty-four per cent (eighty-nine samples) proved to be violative, and legal action was taken, when necessary, to prevent the sale or use of the unfit food or drugs. This reflects a great improvement in the field of food and drug adulteration violations, as 189 of last year's 420 samples analyzed were found to be violative. This is a decrease from 43 to 24 percent in the number of foods and drugs found to be adulterated by the presence of filth, illegal chemicals or other such substances.

Nine hundred and twenty-five dairy barns, and seven pasteurizing plants were constructed at a cost of $1,000,000.

Three thousand two hundred inspections were made in the sanitary supervision of the processing and manufacturing of:

13,000,000 pounds of cheese

7,250,000 pounds of butter
310,000,000 pounds of evaporated milk
2,518,000 pounds of ice cream.

An intensive malaria control program was conducted in 38 counties during the past year. This program included the spraying of 65,315 houses with DDT. Larvacide application, in towns and densely populated areas, to 4,000 miles of ditches and streams, 7,200 acres of ponds and lakes. It promoted and assisted in the rat proofing of 230 establishments, distribution of rat poison in eight areas, and the establishment of organized garbage collection and disposal systems in seven towns. The malaria and typhus control program was financed largely by the $190,000 from voluntary participation. The major accomplishments indicated above under the various divisions of the bureau of sanitary engineering do not include a large amount of time spent on routine activities, such as public health education, regulatory and promotion and sanitary surveys.

In 1950 the Bureau of Vital Statistics processed approximately 161,000 applications, despite a 22% personnel reduction. The work load in 1950 increased approximately 100% over 1948.

Eight construction contracts were awarded during 1950. The contracts amounted to $9,656,000 for 559 beds classified as general hospitals. Thirteen projects have been completed including three state units constructed for the state hospital for mental and nervous diseases, these units being a 100 bed tuberculosis unit at Little Rock, a cold storage plant at Benton, and a laundry unit at Little Rock. The other ten projects are general hospitals with 534 new beds and a total value of $4,820,500.

COMMITTEE ON THE AUXILIARY

R. B. ROBINS, Chairman

The Woman's Auxiliary to the Arkansas Medical Society under the leadership of its President, Mrs. Warren S. Riley, has done a splendid job for medicine in Arkansas during the past year.

The President developed a handbook for officers and committee chairmen which has been acclaimed the most helpful and successful guide that has ever been used by the Auxiliary. This handbook has been highly praised by the National officers. It has served as a tangible source of help and aid to the work of the Auxiliary and the President is to be complimented for this innovation. She has also developed a Statistical Report which has been used for the first time. This form has been very helpful in making a systematic compilation of achievements in an orderly and compact form.

Two new Auxiliaries have been organized during the past year—Clark and Boone Counties. There are now a total of 25 auxiliaries organized in Arkansas. The total membership last year was 658. Many young doctors' wives, who have not been members before, have been enrolled this year and we are confident that the final report will reveal more than 700 members.

Your Committee would like to call special attention to two comparatively new activities of the organization this year: (1) Radio Health Programs. An effort has been made to see that each of the 33 radio stations in Arkansas has carried some type of health program each week as a public service feature; (2) Interprofessional Relations Meetings. Each Auxiliary has been asked to hold one time during the year an interprofessional relations meeting at which time physicians, dentists, druggists, voluntary insurance salesmen and their wives would get together for a dinner and social meeting.

We feel that the Woman's Auxiliary has done and is doing a very fine job in Arkansas and we hope that they will be encouraged in every way possible by the officers and membership of the Arkansas Medical Society to continue their valuable work.

COMMITTEE FOR EXTENSION OF MEDICAL CARE

H. W. THOMAS, Chairman

The Committee for Extension of Medical Care, more commonly called the EMC Committee, met at intervals during 1950-51 at the Albert Pike Hotel, Little Rock. Frequent telephone and telegraphic communications among the committee members served to augment the formal meetings. Because of the nature of the committee's work, this must continue to serve as a means of keeping the committee members, and through them the profession as a whole, aware of current and anticipated activities of certain elements within our government, who seek to destroy the private practice of medicine.

This committee, which was established in 1949, is charged with the responsibility of directing the efforts of the Arkansas Medical Society against "socialized medicine" in its multitude of disguises and camouflages.

There are men in high position in our government, who have shown utter disregard for the expressed will of the great masses of the American public—men who have a ruthless determination to seize unprecedented, unwarranted and unconstitutional power — men who will use every conceivable scheme to acquire more power and control over the private practice of medicine and all private enterprise.

Your EMC committee, with members from all Councilor Districts was established to spearhead the drive of the medical profession of Arkansas against these forces.

Invaluable help has come from the members of the Auxiliary throughout the state. Four representatives of the Auxiliary are members of this committee.

During the past year, our efforts were directed against compulsory health insurance, federal aid to medical education, broadening of the Social Security program and against numerous camouflaged and disguised programs, which purported to meet a dire need (i. e. the National School Health Service Act) but which in reality represented just so many more angles of the "power grab" efforts of such men as Oscar Ewing.

The EMC committee is that arm of your State Society, which activates the program of Whitaker and Baxter of the A.M.A. on the state level in Arkansas. During the past year, Dr. Ralph Gampell's visit to the state for a series of lectures to lay and professional groups on the evils of the British state medicine program was arranged for by this committee. Tie-in advertising stating medicine's case to the people of Arkansas likewise was promoted with success. At present the State Auxiliary is conducting a campaign at the request of this committee to have the Harding College "Freedom Films" shown to every County Society and Auxiliary in the State.

The committee feels that during the past year our profession has made definite gains in mustering public opinion to our support. We feel that we might even have awakened a few slumbering physicians to the dangers that confront us, but we realize full well that the fight has just begun and that money, time and effort must continually be poured into our campaign, if we are to continue as a free profession in a free land.

RURAL HEALTH COMMITTEE

JOE W. REID, Chairman

The Rural Health Committee during 1950 has—

1. Actively supported drives in eight counties for the voluntary pre-paid hospital & medical insurance plans.
2. Organized a few health councils.

3. Supplied display booths in county fairs, giving literature and information concerning the work of our State Health Department and information about voluntary versus compulsory health insurance.

The Committee recommends the establishment at our Medical School of lectures to be given to seniors concerning advantages of practicing in small towns and rural counties. This, we believe, should be given by someone actively engaged in this work.

POSTGRADUATE STUDY COMMITTEE

C. RANDOLPH ELLIS, Chairman

Your Postgraduate Study Committee has arranged with the University of Arkansas School of Medicine to have postgraduate courses of 1-3 days' duration offered at intervals of 2-3 weeks throughout the regular school term. Some of these courses are lectures only; others include lectures, clinic and hospital teaching. The tentative schedule of these courses is as follows:

SCHEDULE OF POSTGRADUATE COURSES 1950-51

Date	Department	Head of Dept.	Number
Oct. (1st half)	Obstetrics & Gynecology	Willis E. Brown	15
Oct. 27	Academy of Gen. Prac.		No limit
Nov. 6-7	Pediatrics	W. A. Reilly	No limit
Nov. 13-16	Southern Med. Society		
Dec. (1st half)	Surgery	G. O. Dean	25
Dec. (2nd half)	None to be held		
Jan. (1st half)	Obstetrics & Gynecology	Willis E. Brown	15
Jan. (2nd half)	Tuberculosis		No limit
Feb. (1st half)	Medicine	B. B. Wells	30
Feb. (2nd half)	Mid South		
Mch. (1st half)	Surgery	G. O. Dean	25
Mch. (2nd half)	Obstetrics & Gynecology	Willis E. Brown	15
Apr. (1st half)	Radiology	I. Meschan	
Apr. 23-25	State Society Meeting		
May (1st half)	Pediatrics	W. A. Reilly	No limit
May (2nd half)	Obstetrics & Gynecology	Willis E. Brown	15
June (1st half)	Surgery	G. O. Dean	25

Detailed information may be obtained about each course by writing to the head of the department concerned.

The Arkansas Medical Society meeting and other prominent meetings near us are included in this schedule in an effort to avoid conflicting dates.

Since our 1950 Annual Session, there have been two courses in obstetrics and gynecology, two in surgery, and one in pediatrics. These were all well-attended. The visiting and local speakers presented subjects of interest especially to physicians in general practice. Limiting the enrollment in some of these courses has made clinic and hospital presentation much easier and has greatly increased interest.

The Arkansas Chapter of the American Academy of General Practice held its Second Annual Postgraduate meeting in the Albert Pike Hotel, Little Rock, October 27, 1950. Attendance was good, with 100 physicians present. The program covered many aspects of medicine, surgery, and obstetrics of interest to the general practitioner.

It is our purpose to expand this postgraduate study program to meet the needs of all members. We urge all members to take the fullest possible advantage of the program already arranged.

We would like to make the following recommendations:

1. That the University of Arkansas School of Medicine be requested to set up a Department of Postgraduate Medicine through which all study courses and lectures may be scheduled and proper records kept.

2. That this committee be notified of all postgraduate lectures or courses planned or requested in the state.

3. That appointments on this committee be made for different periods of service so that it is never composed completely of new members.

4. That the Arkansas Medical Society recommend to the School of Medicine the adoption of plans for a general practice residency program at the earliest practical time.

We express to the Staff of the University of Arkansas School of Medicine our sincere appreciation for their assistance and cooperation in arranging a Postgraduate Study Program.

CANCER CONTROL COMMITTEE

HENRY HOLLENBERG, Chairman

During the past year the activities of this Committee have largely been directed through their association with the State Cancer Commission. Of growing importance are the Tumor Clinics throughout the state which have now received approval of the American College of Surgeons. There is an increasing use of these clinics. The Association of Tumor Clinic Staff Physicians has increased its activities and has had several important meetings with outstanding out-of-state and in-state speakers. Again we have obtained the services of an outstanding out-of-state speaker for the annual meeting of the State Society. This is becoming an annual fixture of our spring meeting.

Members of this Committee have been somewhat concerned at the reported use of Tumor Clinic facilities and other free facilities for diagnosis and treatment by patients who are apparently able to pay. The exact degree of this abuse is not accurately known though we are attempting to investigate and to curtail it. In this connection, it is well for our members to know that the State Cancer Commission now recognizes that the physician who treats the patient is the one who can and should definitely determine their ability to pay. It is therefore agreeable to the State Cancer Commission for physicians who treat patients to make charges when such are in line with the patients able to pay.

TUBERCULOSIS COMMITTEE

JOHN E. GREUTTER, Chairman

The Tuberculosis Committee of the Arkansas Medical Society has remained in contact with Dr. J. D. Riley, Superintendent of the State Sanatorium. During 1950-1951 no current problems have been referred to this committee and no active action has been necessary.

MATERNAL WELFARE COMMITTEE

I. F. JONES, Chairman

The Maternal Welfare Committee wishes to report that the University of Arkansas Medical School in cooperation with the Maternal Welfare Committee, offered a Postgraduate Program at the Medical School during spring of 1950, and is again offering a course in March and May of 1951. These courses seem to be appreciated by the members of the Arkansas Medical Society as reservations for them are at a premium. We feel that these classes should be limited to fifteen registrants and limited to one week. Courses consist of ward rounds, clinics, conferences, lectures and demonstrations. Programs are arranged to insure ample opportunity for informal question periods. Classes begin at 8:00 A. M. and last until approximately 8:00 P. M., with time out for meals.

We feel that these programs have not only aided the practitioners in Arkansas who are doing obstetrics, in material benefit to themselves and patients, but also has brought the University of Arkansas Medical School closer to Society members. It is hoped that these programs in the future will not only be continued, but that more physicians will avail themselves of the opportunity of taking these postgraduate courses.

No further business has come before the Maternal Welfare Committee this year.

CHILD WELFARE COMMITTEE

B. P. BRIGGS, Chairman

1. The question was brought up concerning school health. The Committee recommends that school medical advisors working with a school health committee of the county medical society and the county health department be appointed where feasible. It was further recommended that the above groups use the pamphlet of the Arkansas Department of Education and State Board of Health "A Guide for School Health Program in Arkansas" plus suggested school health policies as outlined in pamphlet of the American Medical Association. This committee approves the program being carried out through the State Health Department and the schools in cooperation with the E.E.N.T. section of the State Medical Society in the conservation of hearing and vision.

2. The Committee was gratified over the reporting of birth weights on the birth certificates. The reporting from a few areas still needs improvement.

3. The Committee noted an increase in neonatal deaths recently and recommended that local medical societies study the neonatal deaths in their localities.

4. The Committee further recommends that individual physicians and local health departments stress early immunization as brought out in recent work whereby routine immunization can be satisfactorily begun as early as the second month.

5. The Committee commends the Well-Child Conferences sponsored by the State Health Department and the local medical societies and believes that these encourage parents to seek further care for children from the private physician.

6. The Committee recommends that in areas where poliomyelitis is treated, as recommended under decentralization of poliomyelitis care by this committee in a previous year, that adequate facilities be provided such as physiotherapy.

7. The Committee feels that present study of the home environment for children with chronic illnesses or disabilities is frequently inadequate. The Committee therefore recommends that better social service studies of the child's home environment be carried out and made available to the attending physician.

This Committee thinks that in many instances convalescent care may be shortened with a lessening of the economic burden, and psychological improvement for the child with better social studies available.

LIAISON COMMITTEE WITH THE ARKANSAS STATE BOARD OF HEALTH

W. B. GRAYSON, Chairman

The State Board of Health and the local health departments throughout the State of Arkansas are charged with the responsibility of protecting the public health, the establishment of sanitary and hygienic living conditions throughout the State, the suppression of infectious, contagious and communicable diseases and the proper enforcement of quarantine, isolation and control of such diseases. There are numerous reasons why, during the past few years, these basic public health provisions have not been carried out on the basis of a minimal adequate standard.

The only way that minimal adequate public health standards and services can ever be maintained in Arkansas is for the state to be covered by an adequate number of full-time local health departments, staffed with well-trained physicians, nurses, and other auxiliary public health workers. At the present time Arkansas falls short of the required number of full-time local health departments. Ten counties are still organized for nursing service only. As of January 1, 1951, local health departments were directed by only eight full-time local health officers and to adequately cover the state a minimum of at least 30 full-time local health officers is needed. At the same time local health departments were staffed by 110 public health nurses when at least 400 public health nurses are needed. At the present time local health departments are served by 55 trained sanitation officers when a total of 130 sanitarians are needed.

The State Health Department has not been in a position to secure the services of professional personnel due to the fact that salaries are far below those of other competitive institutions and facilities. Another major reason for the lack of adequate coverage of local health services through the state is the fact that local units of government have never been in a position to contribute their proportionate share of the expenses and costs of continuing a minimal local health program. Local units of government are badly in need of some provision enabling the general public to vote a millage specifically ear-marked for local public health purposes. At the present time approximately an average of 70 cents per capita is being expended by our local units of government, the State of Arkansas, and the federal government to maintain present local health services when the general consensus of the authorities in preventive medicine is that a minimum of $1.50 per capita is needed to maintain minimal adequate health services.

Since July 1, 1950, the State appropriations for health services within the state have been curtailed to an appreciable degree. This reduction of state funds was necessitated and imposed on all state agencies through the administration's economic demands. During this period federal funds allocated to the state for health purposes were also greatly reduced through the economic demands required by the national emergency.

Even though local health services at present are totally inadequate and the total number of professional workers are far below the number needed to maintain minimal adequate services, the demands on such services by the civilian and national defense programs are rapidly increasing. It will be the endeavor of the Arkansas State Board of Health and the local health departments to continue their efforts in the protection of the public health as well as cooperating to the fullest with the civilian and national defense programs.

LIAISON COMMITTEE WITH THE STATE HOSPITAL FOR NERVOUS DISORDERS

W. J. KETZ, Chairman

It has been unfortunate indeed that the presence of mental disease has always struck fear into the hearts of men, for this fear has always distorted their thinking relative to mental and emotional disorders, and has thereby long prevented those suffering from such disabilities from receiving the care and treatment which they have needed.

Because we have for years neglected to offer those suffering from the disabling effects of mental illness proper care and treatment and because we have let prejudices and superstitions hide from us the true scope of the problem of mental illness, we are now as citizens faced with the fact that mental disease has become the nation's number one health problem and that mental and emotional disorders are adversely affecting the socio-economic conditions of this country and are actually interfering with the overall security of our nation as a whole.

In order that we may better understand this problem let us look at some of the facts and figures relative to mental illness in Arkansas. First, it is of interest to know that of the 61,810 patients admitted to the Arkansas State Hospital since 1882, 36,557, or far better than half, have been admitted during the last twenty years. Secondly, that the hospital admitted 2,008 patients during the year 1949 and that we will admit some 2,400 patients and discharge over 1,850 during the year 1950. Third, that our hospital has an overall population of 4,857 patients housed in its three hospital units. Fourth, that many patients in the Arkansas State Hospital have been more or less continuously hospitalized for from 50 to 60 years at a cost to taxpayers of some $65,000 each. Fifth, that the hospital has within its various units over 150 mentally retarded and deficient children, and 1,140 aged. Sixth, that the number of hospitalized insane in Arkansas will jump from 4,900 to 7,000 by the year 1975 unless some steps are taken to curtail mental illness and that the aged actually needing mental hospital care will increase from around the present 400 mark to 2,400 by 1975. Seventh, that the present methods of treatment have made it possible for the hospital to cut its annual death rate from 640 to 440 in two years and show its patients return rate from 700 per year to 400 in the same period of time.

Those are some of the facts relative to our state mental health problem. To meet this problem the State Hospital has formulated and developed the Arkansas Mental Health Plan in 1949. This plan, which is considered in national circles to be remarkably outstanding, is composed of nine separate phases:

1. The analysis of the actual mental health problem in Arkansas.
2. The establishment of adequate and sufficient hospital space for the care and treatment of the state's mentally ill.
3. The development of adequate, well trained professional staffs to man present and future hospital facilities.
4. The development of adequate research and training facilities for professional staff members.
5. The development of an efficient and effective plan for overall hospital operation and management.
6. The development of sufficient mental hygiene clinics throughout the state.
7. The development of systems of patient follow-up job placement and patient foster home care.
8. The development of a special hospital for the feeble-minded near enough to a center of learning so that these unfortunates may have the benefit of teachers and thereby be enabled to make some type of social or economic adjustment.
9. The development of special centers and hospitals for the aged with the idea of rehabilitating as many of these unfortunates as possible, and with the idea of offering proper hospital care to those beyond the stage of rehabilitation.

The State Hospital has now, for the first time in its history, been approved by the American College of Surgeons, The American Medical Association and The American Hospital Association. These approvals were granted to us on a tentative basis and will be withdrawn unless the hospital is able to meet the rigid approval standards. These standards cannot be met without additional funds and, therefore, we stand to lose approvals unless adequate budgetary funds are made available for supplies, food personnel, etc., by the Legislature.

We have gone as far as possible with the available funds and we must now decide whether we shall continue to develop our treatment and training facilities and offer equal opportunities for treatment to all patients, or whether we will confine our treatment to a limited few and treat the remainder on an asylum basis. The choice, unfortunately, rests not with the doctors who must work with these patients, but with the citizens, for the doctors can do only what the citizens desire and can carry on treatment only to the extent that funds are available.

HOSPITAL RELATIONS COMMITTEE

A. S. KOENIG, Chairman

The first Committee meeting was held in Little Rock December 17, 1950, in joint meeting with the Committee for re-writing the Medical Practice Act. The principal items of discussion were certain features of the new Medical Practice Act which is to be introduced in the Legislature in the 1951 session. These consisted of (1) a precise definition as to what constitutes the practice of medicine and (2) a provision for the restriction of corporate medical practice within this state. Agreement on the principal contents of these two provisions was arrived at by both Committees. Subsequently these provisions were included in the Act which was approved by the Council for introduction into the Legislature.

A discussion was also held on the recommendation that had been made in the previous annual report about a removal of pathological, radiological, anesthesiological and physiatric service from the present Blue Cross Insurance Policies. It was agreed that this recommendation be reintroduced at the next meeting of the House of Delegates, but should be re-worded to include all voluntary types of insurance programs which are offered within this State.

A subsequent meeting of the Hospital Relations Committee was held in conjunction with the Council and Legislative Committees of the Society at a hearing granted representatives of the Arkansas Hospital Association for discussion of provisions of the Medical Practice Act. At that time the various reasons for introducing the provision on corporate Medical Practice were discussed and explained to the members of the Hospital Association.

It is the recommendation of the Hospital Relations Committee that for reasons which were proposed in our previous annual report, coverage for radiological, laboratory, anesthesiological and physiatric service be included in Blue Shield and other voluntary medical service policies and not be retained principally as services offered under hospital coverage type insurance.

MEDICAL EDUCATION COMMITTEE

JAMES M. KOLB, Chairman

The Committee on Medical Education has consisted of the following members this past year: Doctors Willis E. Brown, Little Rock; R. C. Dickinson, Horatio; Henry G. Hollenberg, Little Rock; Louis K. Hundley, Pine Bluff; James M. Kolb, Clarksville; C. C. Long, Ozark and Henry W. Thomas, Dermott.

The Committee met at the University of Arkansas School of Medicine, Little Rock, on May 4, 1950, and outlined its work for the year. On the same date it met with the Liaison Committee of the Pulaski County Medical Society, composed of Doctors Hoyt Allen, Ben Wells, Daniel H. Autry and S. T. W. Cull. Meeting with the above were: Dr. Charles R. Henry, President-Elect, Arkansas Medical Society; Dr. W. C. Langston, Acting Dean, University of Arkansas School of Medicine; Dr. Henry C. Chennault, Retired Vice-President, University of Arkansas School of Medicine; and Mr. K. W. Newman, Director of the Hospital Admissions and Clinic of the University of Arkansas

School of Medicine. A lengthy discussion was held concerning the operation of the medical school, the hospital and the proposed new medical center. No conclusions were agreed upon, but many misunderstandings were brought to light. Henry Hollenberg was asked to contact Dr. Lewis Webster Jones, President of the University of Arkansas, Governor Sid McMath and Mr. Jack Stevens, member of the Board of Trustees, University of Arkansas, and to report to the Committee as soon as possible.

The Committee met at Little Rock on June 11, 1950, to receive Doctor Hollenberg's report of his conversations with Dr. Lewis Webster Jones, Governor Sid McMath and Mr. Jack Stevens. After much discussion it was felt that a written statement should be secured from Doctor Jones and Governor McMath. A proposed "Statement of Policy" was drawn up and presented to the Council of the Arkansas Medical Society for approval. After their approval was secured, it was forwarded to Doctor Jones. The Trustees of the University of Arkansas adopted it, and it was published in the Journal of the Arkansas Medical Society, September, 1950, Page 76.

Several meetings of the Committee were held in conjunction with the Council of the Arkansas Medical Society during the fall. They concerned the proposed Medical Center. The Committee recommended to the Council that it reaffirm its approval of the proposed Medical Center. This, the Council did.

The Committee met January 28, 1951, at Little Rock, together with the Committee on Postgraduate Study. Also present were: Drs. Earle H. Hunt, President, Arkansas Medical Society; Charles R. Henry, President-Elect, Arkansas Medical Society; and H. C. Nicholson, Dean, University of Arkansas School of Medicine. This joint meeting was called, at the suggestion of Doctor Hunt, to consider a proposed program of Doctor Nicholson regarding the establishment of a General Practice Residency at the University Hospital. After much discussion the adoption of such a program was recommended. It is, as follows:

GENERAL PRACTICE RESIDENCY PROGRAM

Operation

First Year of General Practice Residency (Internship)

I. This would be essentially the same as the present rotating internship. Physicians entering upon this course would not be required to commit themselves to a career in general practice but in selecting them those who have a definite tendency toward this area of medical work would be favored.

II. Arrangements would be made for a series of seminars and clinical conferences at no less than weekly intervals. These would be conducted as far as possible by qualified general practitioners or by men of long experience in the private practice of medicine. It would be very important to have the subject matter of these conferences suggested by general practitioners, especially those of recent graduation who realize the defects in their own training. These seminars should be conducted exclusively for the benefit of the house staff group. The temptation to bring undergraduate teaching and specialty motives into this program should be resisted. (It appears that one of the outstanding defects of the present intern training program is the failure to have conferences conducted for the exclusive benefit of the interns. Although it is true that a large number of good teaching conferences are available to these men, the idea of having a session devoted to their exclusive benefit would have had an important effect upon the group morale.)

Second Year of General Practice Residency

I. To establish office and examining rooms for 6-12 men. These men would see new patients as they come into admitting office at rate of about four new patients per day. These patients would come from Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, and Psychiatry. Two physicians would share office and examining room facilities so that one physician would have office hours in the morning and the other in the afternoon. When the resident physician was out of the office he would make hospital rounds, take special problem cases to other clinics for consultation, work one-half day a week in the Emergency Room, attend clinics and seminars, etc.

II. Patients that needed hospitalization would be admitted through the regular channels and be handled by him under supervision in the house—the general practitioner serving as assistant or surgeon in surgical cases, as accoucheur in obstetric cases, etc.

III. Return visits (Emergency Room, Clinic, or Hospital) would be scheduled with the same general practice resident physician.

Location

Several areas could be made available for this activity. A separate building could be developed in the parking area or one of the store rooms could be equipped. Better still is the area of storage in the housekeeping area.

Establishment of small waiting room and clerk's desk with two small offices and an examining room between would serve each two men (6 men, 3 examining rooms, etc.).

Supervision

The supervision of these clinics should be by general practitioners in practice known as associates of assistant professors in general practice. They would be selected for their high caliber of practice and interest in this program, administrative supervision to be under the Director of Postgraduate Medicine.

The general practice resident should be given an opportunity to learn:

A. Radiographic techniques and interpretations within the limits of general practice.

B. The equipment and operation of a small office and laboratory as can be used to advantage in general practice.

C. Economic and ethical principles involved in general practice.

D. The use of state institutions and welfare agencies for the benefit of his patients, such as the State Tuberculosis Sanatorium, Visiting Nurses Program, and State Rehabilitation Program, Venereal Disease Program, the State Hygienic Laboratory facilities, etc.

E. A considerable number of projects can be listed under this general category. The ones given here will serve as examples.

The Chairman wishes to express his appreciation to the members of his Committee for their aid, advice and cooperation, and especially to Dr. Henry Hollenberg for his liaison work with Dr. Lewis Webster Jones, Governor Sid McMath and the Trustees of the University of Arkansas.

HEART COMMITTEE

C. T. CHAMBERLAIN, Chairman

The Heart Committee has carried out no specific scientific program this year since its activities have been devoted largely to organization of the Arkansas Heart Association, Inc., and to participation in and execution of the two annual campaigns in February, 1950 and February, 1951, respectively.

REPORT OF THE EXECUTIVE SECRETARY

Mr. SID WRIGHTSMAN, JR.

Your executive secretary is pleased to report that, during 1950, Society members, as well as State medical societies elsewhere, appeared more aware of the existence of the headquarters office at Fort Smith and unhesitatingly used its facilities in all aspects.

As 1950 was the initial year of compulsory membership dues in the American Medical Association, in addition to the annual assessment of this Society, a considerable collecting, bookkeeping and banking problem fell to this office. Frequent bulletins, encouraging such payment from delinquent members, were issued throughout the year. Of the 1,168 members in-good-standing of the Society at the year's end, approximately 925 remitted the AMA 1950 membership dues. On a percentage basis, the Arkansas Medical Society appeared thirtieth on the list of State Societies in collection of the national dues.

In June, the headquarters office was moved from its one-room quarters in 310 Professional Building to a two-room suite in 311-312 Professional Building at a nominal increase of rent. Such a move has proved advantageous because of the additional space allotted for the establishment of a complete file of issues of The Journal of the Arkansas Medical Society dating back to 1903 and the creation of a "work" room for mimeographing and other necessary procedures involved in all-membership mailings.

This office maintained even closer alliance with the American Medical Association headquarters and the firm of Whitaker & Baxter during 1950 in disseminating important legislative information to members, under the direction of the Committee for the Extension of Medical Care of the Arkansas Medical Society. Its position as a state focal point of distribution during the AMA advertising campaign in the fall was invaluable.

Your executive secretary represented the Society at the AMA Annual Session at San Francisco in June and the so-called Clinical Session at Cleveland in December. Furthermore, his many contacts thereat will doubtlessly prove helpful in time to come.

At the suggestion of the Society's auditing firm, a new double-entry bookkeeping system was inaugurated following the 1950 Annual Session and is being ably accomplished by Miss Jeanne Kerwin of Fort Smith, now in permanent employ at the Society headquarters office as assistant to the executive secretary. Her excellent grasp of Society activities and procedures and her industry in all her official duties have made her a valuable asset to the Arkansas Medical Society.

It is your executive secretary's recommendation that the Society give careful consideration to the establishment of an annual budget during succeeding years, the drawing-up of which might best be undertaken by a Council-appointed Budget Committee. Because of the ever-increasing expenditures necessitated in the progress and expansion of Society activities, particularly during these critical legislative years, such a budget would seem of utmost importance to the financial welfare of the Arkansas Medical Society in years to come.

For their continuous cooperation and innumerable courtesies extended him throughout the past year, the executive secretary expresses profound appreciation to officers and members of the Arkansas Medical Society.

PRELIMINARY PROGRAM

SEVENTY-FIFTH ANNUAL SESSION ARKANSAS MEDICAL SOCIETY

Hotel Marion
Little Rock, Arkansas
April 23, 24, 25, 1951

Sunday, April 22nd, 8:00 P. M.

The Council will meet in session preliminary to the Annual Session at the Hotel Marion.

Monday, April 23rd, 9:30 A. M.

Invocation.

President's Address—Earle H. Hunt, M. D., Clarksville.

"The Why of the Academy of the General Practitioners"—John R. Bender, M. D., Winston-Salem, N. C.

"Jaundice"—Philip Thorek, M. D., Chicago, Ill.

"Differential Diagnosis and Treatment of Collagen Diseases"—Col. Charles T. Young, Army and Navy General Hospital, Hot Springs.

"Newer Drugs in the Treatment of Epilepsy"—Meyer A. Perlstein, M. D., Chicago, Ill.

"Cancer of the Lung with Case Histories, Symptoms and X-Ray Procedures"—D. A. Rhinehart, M. D., Little Rock.

Monday, April 23rd, 1:30 P. M.

"Vertigo and Tinnitis"—Edmund P. Fowler, Jr., M. D., New York, N. Y.

"Physician-Nurse Relationship"—Mrs. Catherine Hockaday, President, Arkansas State Nurses Association, Pine Bluff.

"The Role of the General Practitioner in the Rural Health Program"—Mr. Aubrey Gates, Committee on Rural Health, American Medical Association, Chicago, Ill.

"Management of Breast Lesions"—James H. Growdon, M. D., Little Rock.

"The Optimum Age and Procedure of Choice for Elective Surgery in Infancy and Childhood"—Luther A. Longino, Jr., M. D., Boston, Mass.

"Urinary Tract Infections"—Gerald H. Teasley, M. D., Texarkana.

Monday, April 23, 4:00 P. M.

HOUSE OF DELEGATES.

Tuesday, April 24th, 9:30 A. M.

PEDIATRIC, OBSTETRIC AND GYNECOLOGY SYMPOSIUM—Charles R. Henry, M. D., Little Rock, Moderator.

"Obstetric Problems in Fetal and Neonatal Mortality"—Carl P. Huber, M. D., Indianapolis, Ind.

"Infant Feeding"—Ernest H. Watson, M. D., Ann Arbor, Mich.

"Erythroblastosis"—William F. Mengert, M. D., Dallas, Texas.

"Rh Incompatibility from Pediatric Standpoint"—William G. Klingberg, M. D., St. Louis, Mo.

Tuesday, April 24th, 11:30 A. M.

MEMORIAL SERVICE.

Tuesday, April 24th, 2:00 P. M.

"Stellate Ganglion Injection in Cerebral Vascular Diseases"—Robert Watson, M. D., Little Rock.

"Early Clinical Diagnosis of Carcinoma of the Lung"—J. K. Donaldson, M. D., Little Rock.
"Cancer of the Larynx"—Paul Mahoney, M. D.; Jack Brizzolara, M. D., Little Rock.
"Ophthalmology for the Family Doctor"—John Dodson, Jr., M. D., Hot Springs.
"Facts on Tuberculosis in Arkansas"—A. C. Curtis, M. D., Little Rock.
"Bursitis in the Shoulder"—A. M. Davison, M. D., Hot Springs.

Tuesday Evening, April 24th, 6:30 P. M.

Social Hour, Buffet Supper and Dance, Hotel Marion.

Wednesday, April 25th, 9:00 A. M.

"Cancer of the Esophagus"—Thomas H. Burford, M. D., St. Louis, Mo.
"Report of Blue Cross-Blue Shield Program"—Ellery C. Gay, M. D., Little Rock.
"Fractures of the Humerus"—John M. Hundley, M. D., Little Rock.
"The Care of Premature Infants in Arkansas"—Frances C. Rothert, M. D.; Myron M. Nichols, M. D., Little Rock.
"Infertility and Sterility"—Paul H. Woods, M. D., Hot Springs.

Wednesday, April 25th, 1:30 P. M.

HOUSE OF DELEGATES.

SPECIAL SECTION PROGRAMS

EENT SECTION PROGRAM

Tuesday, April 24th, 10:00 A. M.
Hotel Marion

Chairman's Address—Paul L. Mahoney, M. D., Little Rock.
"Chronic Infection of the Middle Ear"—Robert H. Atkinson, M. D., Hot Springs.
"Management of the Deaf and Hard of Hearing Pre-School Child"—Edmund P. Fowler, Jr., M. D., New York, N. Y.

12:15 P. M.

Luncheon with Round-Table Discussion.

2:00 P. M.

"Intra-Ocular Foreign Bodies"—Gardner Landers, M. D.; George C. Burton, M. D., El Dorado.
"Newer Treatment of Ocular Syphilis"—Leslie C. Drews, M. D., St. Louis, Mo.

OBSTETRICS-GYNECOLOGY SECTION PROGRAM

Tuesday, April 24th, 2:00 P. M.
Hotel Marion

"Carcinoma of the Uterus"—John C. Weed, M. D., New Orleans, La.
"Obstetric Hemorrhage"—Carl P. Huber, M. D., Indianapolis, Ind.
"Geriatric Gynecology"—(to be announced).
"Toxemia and Eclampsia"—William F. Mengert, M. D., Dallas, Texas.
"Functional Uterine Bleeding"—Phillip S. Schreier, M. D., Memphis, Tenn.
Question-Answer Period—Eugene T. Ellison, M. D., Texarkana, Moderator.

PEDIATRIC SECTION PROGRAM

Tuesday, April 24th, 2:00 P. M.
Hotel Marion

"Immunization in Infancy and Childhood"—Ernest H. Watson, M. D., Ann Arbor, Mich.
"The Importance of Early Diagnosis in Contagious Disease Management"—Archibald L. Hoyne, M. D., Chicago, Ill.
"Unexplained Fever in Childhood"—Fred M. Taylor, M. D., Houston, Texas.
"Amniopterin Therapy in Leukemia"—William G. Klingberg, M. D., St. Louis, Mo.
"ACTH and Cortisone in Pediatrics"—David Goldring, M. D., St. Louis, Mo.
Question-Answer Period—(Moderator to be announced).

SPECIAL PRELIMINARY ANNOUNCEMENTS

All Society members and guests are welcome to attend the special Section Programs on Obstetrics-Gynecology and Pediatrics on Tuesday afternoon, April 24th, including a special Ob.-Gyn.-Pediatrics "dutch treat" luncheon, Tuesday, 12:15 P. M., at the Hotel Marion.

The annual Society golf tournament will be held Tuesday, April 24th, 1:00 P. M., at the Riverdale Country Club. A $1.00 green fee will be charged.

PRELIMINARY PROGRAM

TWENTY-SEVENTH ANNUAL SESSION WOMAN'S AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY

Hotel Marion
Little Rock, Arkansas
April 23, 24, 25, 1951

OFFICERS

PRESIDENT—Mrs. Warren S. Riley, El Dorado.
PRESIDENT-ELECT—Mrs. J. G. Martindale, Hope.
FIRST VICE-PRESIDENT—Mrs. Gordon P. Oates, Little Rock.
SECOND VICE-PRESIDENT—Mrs. R. C. Dickinson, Horatio.
THIRD VICE-PRESIDENT—Mrs. Ralph Weddington, Fayetteville.
FOURTH VICE-PRESIDENT—Mrs. A. A. Little, Texarkana.
RECORDING SECRETARY—Mrs. Mason G. Lawson, Little Rock.
CORRESPONDING SECRETARY—Mrs. Gardner H. Landers, El Dorado.
TREASURER—Mrs. V. T. Webb, Little Rock.
PUBLICITY SECRETARY—Mrs. Joe Verser, Harrisburg.
HISTORIAN—Mrs. C. W. Garrison, Little Rock.
PARLIAMENTARIAN — Mrs. Homer K. Wright, Hot Springs.
POET LAUREATE—Mrs. George B. Fletcher, Hot Springs.

ADVISORY BOARD

Dr. R. B. Robins, Camden, Chairman.
Dr. Charles R. Henry, Little Rock.
Dr. Joe Verser, Harrisburg.

COUNCILORS

Mrs. E. L. Thompson, Hot Springs.
Mrs. Fred Hames, Pine Bluff.
Mrs. W. J. Hunt, Warren.
Mrs. M. G. Lawson, Little Rock.
Mrs. L. K. Hundley, Pine Bluff.

COMMITTEE CHAIRMEN

ARCHIVES—Mrs. Joe Rushton, Magnolia.
BIOGRAPHY—Mrs. Charles W. Dixon, Gould.
BULLETIN—Mrs. R. L. Turnbow, Little Rock.
CANCER CONTROL—Mrs. Leo Aday, Little Rock.
CONSTITUTION AND BY-LAWS — Mrs. P. H. Muse, Junction City.
DOCTOR'S DAY—Mrs. Don W. Dykstra, Little Rock.
EDUCATION AND PUBLIC HEALTH—Mrs. R. C. Dickinson, Horatio.
ERLE CHAMBERS MEMORIAL LIBRARY FUND—Mrs. J. B. Crawford, Little Rock.
EXHIBITS—Mrs. H. L. Brown, Malvern.

EXTENSION OF MEDICAL CARE—Mrs. Louis K. Hundley, Pine Bluff.
FINANCE—Mrs. Barton A. Rhinehart, Little Rock.
ILSE F. OATES STUDENT LOAN FUND — Mrs. C. E. Oates, North Little Rock.
JANE TODD CRAWFORD MEMORIAL STUDENT LOAN FUND—Mrs. Pelham McGehee, Lake Village.
LEGISLATION—Mrs. Charles R. Henry, Little Rock.
MARTHA HARDING GANN MEMORIAL LOAN FUND —Mrs. Curtis W. Jones, Benton.
MEMBERS-AT-LARGE—Mrs. J. B. Hesterly, Prescott.
MEMBERSHIP—Mrs. J. G. Martindale, Hope.
MEMORIAL AND CHAPLAIN—Mrs. W. M. Lamb, Paragould.
NURSE RECRUITMENT—Mrs. W. G. Cooper, Little Rock.
ORGANIZATION—Mrs. Gordon P. Oates, Little Rock.
PUBLICITY—Mrs. Joe Verser, Harrisburg.
PUBLIC RELATIONS—Mrs. A. A. Little, Texarkana.
PHYSICAL HEALTH EXAMINATIONS—Mrs. Brian Barlow, Dermott.
PROGRAM—Mrs. Garland Murphy, Jr., El Dorado.
RADIO—Mrs. L. G. Fincher, El Dorado.
RESEARCH AND ROMANCE OF MEDICINE — Mrs. Charles Weber, Magnolia.
TODAY'S HEALTH—Mrs. Ralph Weddington, Fayetteville.

DISTRICT COUNCIL WOMEN

District 1—Mrs. Paul Stroud, Jonesboro.
District 2—Mrs. O. J. T. Johnston, Batesville.
District 3—Mrs. E. D. McKnight, Brinkley.
District 4—Mrs. James T. Rhyne, Pine Bluff.
District 5—Mrs. Harry Atkinson, Fordyce.
District 6—Mrs. Cyrus P. Klein, Texarkana.
District 7—Mrs. H. King Wade, Sr., Hot Springs.
District 8—Mrs. Erner Jones, Little Rock.
District 9—Mrs. Ross Fowler, Harrison.
District 10—Mrs. W. A. Fowler, Fayetteville.

COUNTY PRESIDENTS

ARKANSAS—Mrs. R. H. Whitehead, Sr., DeWitt.
BOONE—Mrs. Ulys Jackson, Harrison.
BOWIE-MILLER—Mrs. N. W. Peacock, Ashdown.
CLARK—Mrs. Jack Kennedy, Arkadelphia.
COLUMBIA—Mrs. H. H. Kitchens, Waldo.
CRAIGHEAD-POINSETT—Mrs. Paul Stroud, Jonesboro.
GARLAND—Mrs. John W. Dodson, Hot Springs.
GREENE-CLAY—Mrs. A. D. Garner, Paragould.
HEMPSTEAD—Mrs. J. W. Branch, Hope.
HOT SPRING—Mrs. John W. Cole, Malvern.
HOWARD-PIKE—Mrs. Edwin Dildy, Nashville.
INDEPENDENCE—Mrs. W. H. Calaway, Batesville.
JACKSON—Mrs. M. H. Harris, Newport.
JEFFERSON—Mrs. Howard Stern, Pine Bluff.
JOHNSON—Mrs. E. H. Hunt, Clarksville.
MONROE—Mrs. E. D. McKnight, Brinkley.
NINTH COUNCILOR DISTRICT — Mrs. Henry V. Kirby, Harrison.
OUACHITA—Mrs. Tom Meek, Camden.
POPE-YELL—Mrs. W. O. Young, Jr., Russellville.
PULASKI—Mrs. T. D. Brown, Little Rock.
SEBASTIAN—Mrs. W. L. Shippey, Fort Smith.
SEVIER—Mrs. Pierre Redman, Mena.
SOUTHEAST ARKANSAS—Mrs. Lewis Hyatt, Monticello.
UNION—Mrs. Paul Henley, Smackover.
WASHINGTON—Mrs. W. J. Stocker, Fayetteville.

DELEGATES TO THE ARKANSAS LEGISLATIVE LEAGUE

Mrs. Charles R. Henry, Little Rock.
Mrs. Mason G. Lawson, Little Rock.

COUNCIL WOMAN TO THE AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION

Mrs. Gordon P. Oates, Little Rock.

LOCAL COMMITTEE CHAIRMEN ON CONVENTION ARRANGEMENTS

GENERAL CHAIRMAN—Mrs. Don W. Dykstra.
ENTERTAINMENT—Mrs. Paul W. Hoover.
REGISTRATION AND CREDENTIALS — Mrs. Paul M. Fulmer.
TICKETS—Mrs. Fred Harris.
COURTESY—Mrs. H. W. Sterling.
PUBLICITY—Mrs. Gordon P. Oates.
MENU—Mrs. Clyde Rodgers - Mrs. Charles Wickard.
FLOWERS—Mrs. Ewell I. Thompson - Mrs. W. J. Schwarz.
PAST-PRESIDENT'S BREAKFAST—Mrs. B. A. Rhinehart.
GENERAL INFORMATION—Mrs. James Newbill.
FINANCE—Mrs. J. K. Donaldson.
FAVORS—Mrs. Gordon P. Oates.
PAGE to Mrs. Warren S. Riley, President—Mrs. Doyle Fulmer.

PROGRAM

Monday, April 23, 1951
Hotel Marion

9:00 A. M.—Registration, Ante-room to Continental Room.

11:00 A. M.—Pre-Convention Board Meeting.

12:00 Noon—LUNCHEON for General Membership, Continental Room.
Presiding—Mrs. Warren S. Riley, President.
Invocation—Mrs. C. W. Garrison, Little Rock.
Address—Dr. R. B. Robins, Advisory Council Chairman, Camden.
Address—Mrs. L. T. Thompson, President, Woman's Auxiliary to the Southern Medical Association, Dallas, Texas.

General Session

2:00 P. M.—Opening of Session, Continental Room.
Presiding—Mrs. T. D. Brown, President, Woman's Auxiliary to the Pulaski County Medical Society.
Invocation—Mrs. W. J. Hunt, Warren.
Address of Welcome—Mrs. Ben D. Means, Little Rock.
Introduction of the State President — Mrs. Warren S. Riley, El Dorado.
Response to the Address of Welcome—Mrs. Joe Rushton, Magnolia.







Photographs courtesy of Louis H. Block, M. D., Chicago

a. Ulcerative amebiasis during Diodoquin therapy. In this patient with severe hemorrhage, edema and necrosis, the ulcers show healing, with many scars. No active lesians are seen.

b. Three manths later, after continuing Diodaquin therapy, extensive scarring indicates healing. Inflammation is further reduced and anly superficial areas of inflammation remain.

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

1. Johnson, S. K.: Mississippi Doctor 27:69 (July) 1949.
2. Merritt, W.: J. Florida M. A. 35:351 (Dec.) 1948.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

Introduction of Special Guests—Mrs. Harold F. Walquist, President-Elect, Woman's Auxiliary to the American Medical Association, Minneapolis, Minn.; Mrs. L. T. Thompson, President, Woman's Auxiliary to the Southern Medical Association, Dallas, Texas; Mrs. Mason G. Lawson, Third Vice-President, Woman's Auxiliary to the American Medical Association, Little Rock, Ark.

Reports of the Officers.

Reports of the Committee Chairmen.

Report of the Seventh Annual Conference of the Woman's Auxiliary to the American Medical Association—Mrs. J. G. Martindale, Hope.

Report of the Convention of the Woman's Auxiliary to the American Medical Association—Mrs. Louis K. Hundley, Pine Bluff.

Report of the Meeting of the Woman's Auxiliary to the Southern Medical Association — Mrs. Gordon P. Oates, Little Rock.

Announcement of Special Committees—Mrs. Don W. Dykstra, Little Rock.

Report of the Registration and Credentials Committee—Mrs. Paul M. Fulmer, Little Rock.

Timekeeper — Mrs. Mason G. Lawson, Recording Secretary, Little Rock.

Tuesday, April 24, 1951
Hotel Marion

8:30 A. M.—Past-President's Breakfast, Parlor B — Mrs. B. A. Rhinehart, Chairman, Little Rock.

9:30 A. M.—General Session—Continental Pdr. Room.

Meeting Called to Order—Presiding, Mrs. Warren S. Riley, President.

Invocation—Mrs. E. D. McKnight, Brinkley.

Reading of the Minutes.

Address—Dr. Earle Hunt, President, Arkansas Medical Society, Clarksville.

Report of the Presidents of County Auxiliaries.

Report of the Registration and Credentials Committee—Mrs. Paul M. Fulmer, Little Rock.

Election of Delegates to the Convention of the Woman's Auxiliary to the American Medical Association.

Election of Officers.

Announcement of the Entertainment Committee—Mrs. Paul W. Hoover, Little Rock.

Timekeeper—Mrs. Mason G. Lawson, Recording Secretary, Little Rock.

11:30 A. M.—Memorial Session—Joint Session with the Arkansas Medical Society—Ball Room.

1:00 P. M.—Luncheon—Continental Room.

Toastmistress—Mrs. T. D. Brown, Little Rock.

Invocation — Mrs. Alvin Longstreth, Little Rock.

Introduction of Past Presidents.

Introduction of State Officers.

Introduction of Wives of Officers of the Arkansas Medical Society.

Introduction of the Poet Laureate — Mrs. George B. Fletcher, Hot Springs.

Address—Mrs. Harold F. Walquist, President-Elect, Woman's Auxiliary to the American Medical Association, Minneapolis, Minn.

Presentation of Certificates of Merit—Mrs. Gardner Landers, El Dorado.

Unfinished Business.

Report of the Committee of Courtesy Resolutions—Mrs. Howard Stern, Pine Bluff.

Installation of the 1951-1952 Officers.

Presentation of the Gavel—Mrs. Warren S. Riley.

Address of the Incoming President—Mrs. J. G. Martindale.

7:00 P. M.—Buffet Supper and Dance, Ball Room.

Wednesday, April 25, 1951

9:30 A. M.—Post Convention Board Meeting and School of Instruction, Continental Pdr. Room. For State Officers, Members of the Board and County Presidents.

Presiding—Mrs. J. G. Martindale, Hope.

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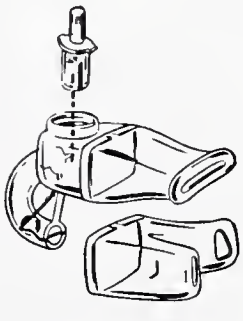
Let us make this point clear at the beginning. We do not recommend penicillin powder inhalation therapy with the AEROHALOR as a cure for the virus cold. It is not. But Krasno and Rhoads[1] have some interesting observations:

"The course of ordinary colds is strikingly shortened by prompt use of the penicillin dust inhalation. We have no illusions that it is effective against virus that initiates the common cold or any other viruses."

The authors also report: "We are fully aware that the etiologic agent of the common cold is probably not a penicillin-sensitive organism. Secondary invaders undoubtedly account for the accentuation of the initial symptoms and in most instances for the more serious complications. Dramatic results often are seen in those patients in whom the cold has been hanging on."

As to the therapeutic effectiveness of inhaled penicillin dust, Krasno and Rhoads state "with assurance" that "bacterial infections of the nasopharynx, para-nasal sinuses, nasal mucosa, larynx and trachea of fairly recent origin, respond well to this form of treatment."

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*Trade Mark for Abbott Sifter Cartridge. AEROHALOR and AEROHALOR Cartridge patented in U. S. and Foreign Countries.

1 Krasno, L., and Rhoads, P. (1949), The Inhalation of Penicillin Dust, Its Proper Role in the Management of Respiratory Infections, Amer. Prac., II:649, July.

WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary to the Craighead-Poinsett County Medical Society met with the Doctors Wednesday evening, February 7, at the Country Club in Jonesboro. After dinner the Marked Tree Ensemble, directed by Pop Hodge, entertained the group with their singing.

The Auxiliary met in an adjoining room for their business meeting. Mrs. Paul Stroud presided over the business meeting. Twelve members and four guests were present. Mrs. Ernest Stroud, Chairman of the Membership Committee, reported that she contacted all doctors' wives in the two counties urging them to attend the Auxiliary meetings. The President reported that a donation had been made to the Martha Harding Gann Memorial Fund.

Mrs. L. H. McDaniel, Chairman of the Nominating Committee, gave a report of the new officers for 1951-52.

Mrs. Grover D. Poole—President.

Mrs. R. C. Shanlever—Vice-President

Mrs. M. O. Peeler—Secretary-Treasurer

It was suggested that the Auxiliary sponsor a dance, the proceeds to go to the Heart Fund. Mrs. Stroud appointed Mrs. O. T. Cohen to make further plans and report at our next regular meeting.

Members of the Auxiliary to the Southeast Arkansas Medical Society met jointly with the doctors Monday night, December 18, 1950, at the Greystone Hotel in McGehee for the annual Christmas party. The dining room was beautiful with its Christmas decorations. After a delicious turkey dinner with all the trimmings, the group sang "Silent Night." Mrs. Kimbro, of Tillar, a guest, favored the group by playing several numbers on the piano. Games were directed by Mrs. H. T. Smith of McGehee.

Dr. Charles Leverett acted as Santa and visited every one with a bag of toys for each to make a selection. Those receiving musical instruments assembled forming a band and played their instruments, accompanied by Mrs. Kimbro at the piano.

There were twenty-eight present, including two guests. Everyone in attendance spent a most enjoyable evening, thanks to the gracious hosts and hostesses of McGehee.

Mrs. Van C. Binns,
Publicity Chairman.

The Auxiliary to the Sebastian County Medical Society met at the McCartney House, Fort Smith, on February 12th. Officers for 1951 were elected and are as follows: President, Mrs. Everett C. Moulton, Jr.; Secretary, Mrs. Marlin B. Hoge and Treasurer, Mrs. S. Wright Hawkins, all of Fort Smith. Following luncheon, Dr. A. S. Koenig, Fort Smith, spoke on "Medical Legislation Now Pending in the Arkansas Legislature."

Mrs. Everett C. Moulton, Jr.,
Publicity Chairman.

The members of the Auxiliary to the Howard-Pike Medical Society entertained with a luncheon at the Garner Hotel at 1:00 o'clock February 9th honoring our President, Mrs. Warren S. Riley of El Dorado, and our President-Elect, Mrs. James Martindale of Hope.

The table was centered with two low bowls of red tulips. Silver candelabras holding tall red candles were placed the length of the table. Corsages were presented to the honorees. Fourteen members were present.

Mrs. Edwin Dildy, President, welcomed and introduced the guests of honor. Mrs. Riley spoke to the group on the Auxiliary's work in Arkansas; Mrs. Martindale spoke on her plans for the coming year.

Hostesses for the luncheon were Mrs. Marion Mabry, Mrs. Ed Hopkins, Jr., and Mrs. J. W. Scoggin.

Mrs. Edwin Dildy.

The January meeting of the Auxiliary to the Garland County Medical Society met at the home of Mrs. John Dodson, President, with Mrs. O. A. Smith, Mrs. Cecil Parkerson and Mrs. Paul Woods as co-hostesses. Refreshments were served by the hostesses before the business meeting.

The meeting was called to order by the President and the minutes of the last meeting were read and approved. Mrs. Frank Burton first reported on plans for raising funds. She stated that we will be unable to have an antique show but she has made arrangements with Mrs. Mendal to have a style show in April. She also reported that it may be possible to have a showing of Kempners shoes and men's apparel from Clyde's Men's Store, if models can be obtained. The show will probably be held at Belvedere Country Club with more definite plans as to price, time and food to be decided upon by the Committee. Mrs. Burton also stated plans for the annual Auxiliary luncheon to be held at 1:00 P. M., February 19, at the Arlington Hotel.



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Mrs. Dodson appointed the nominating committee. Mrs. Charles Lutterloh, Chairman; Mrs. Euclid Smith, Mrs. Walter Klugh, Mrs. James Chesnutt and Mrs. Lehman King.

Mrs. Dodson introduced new positions of the officers, which were voted upon and approved by the Auxiliary.

Mrs. Lehman King gave the Treasury report in the absence of Mrs. Jack Wright. She stated that we have $128.40 in the treasury. She stated 36 members have paid their dues.

Mrs. Chesnutt, program chairman in the absence of Mrs. Jim Leatherman, introduced our speakers for the afternoon. Mrs. H. King Wade, Jr., spoke on training facilities for doctors and nurses in Arkansas. Mrs. Loren Bohnen spoke on the facilities of the colored people and Mrs. Bob Atkinson read a paper on Southern Regional Planning. Lengthy discussion followed each speakers talk. They were all very informative and interesting.

Mrs. Gus Davison was introduced as a new member.

Mrs. Chesnutt attended a meeting of the AAUW and reported that they wanted to make a study of Mental Hygiene in Arkansas and would like to have a committee appointed from our Auxiliary. No definite members were appointed but Mrs. Dodson said she would arrange it later. Meeting was adjourned.

Mrs. E. K. Clardy, Secretary.

The Greene-Clay County Medical Auxiliary met February 14 with the doctors in a joint dinner meeting in the Lecture Room of the Community Hospital.

Mrs. William R. Brooksher, State Commander of the Arkansas Cancer Society, spoke to the Auxiliary on "The Control of Cancer and the Need for Early Diagnosis." She was the guest of Dr. and Mrs. Dillon Garner.

The officers for the new year are:
President, Mrs. Clark M. Baker.
Vice-President, Mrs. Wiley Turner, Jr.
Secretary, Mrs. Dillon Garner.
Treasurer, Mrs. Earl D. McKelvey.

The Auxiliary voted to send a contribution to the Martha Harding Gann Memorial Nurses Fund.

Plans for observance of Doctor's Day were made. The Auxiliary will honor the doctors at a supper party on March 30th.

Mrs. A. D. Garner.

Our first meeting was held January 9th at the home of Mrs. Jim McKenzie. Mrs. James Branch, President, presided over the business. Mrs. Jim McKenzie and Mrs. Walter Sims were appointed delegates to the State Convention.

The election of officers are as follows:
President-Elect, Mrs. Walter Sims.
1st Vice-President, Mrs. Jim Martindale.
2nd Vice-President, Mrs. Jud Martindale.
3rd Vice-President, Mrs. James Branch.
4th Vice-President, Mrs. John Barrow.
Nurse Recruitment, Mrs. George Wright.
Constitution and By-Laws, Mrs. Jim Martindale.
Legislation, Mrs. Walter Sims.
Doctor's Day, Mrs. George Wright.
Cancer Control, Mrs. Don Smith.
Extensive Medical Care, Mrs. Jud Martindale.
Education and Public Health, Mrs. Walter Sims.
Student Nurse Loan Fund—Mrs. John Barrow.

Mrs. Jim Martindale read a very interesting poem "Doc's Writing Is Right Porely."

On January 30th a film entitled "Girls in White" was shown to High School Juniors and Seniors who were interested in making nursing a career. A letter was written to State Nurses Association asking for material to be placed in the High School which might encourage girls to become nurses.

For our doctor's day a dinner for the doctors and wives is being planned at the Hotel Barlow.

Seven members were present.

Mrs. George Wright, Secretary.

Mrs. James G. Martindale and Mrs. Jud Martindale, of Hope, invited the members of the Woman's Auxiliary to the Hempstead County Medical Society to the home of the former on Friday evening, February 9th, to meet Mrs. Warren S. Riley, President of the Woman's Auxiliary to the Arkansas Medical Society.

The reception rooms of the spacious Martindale home were beautifully decorated with arrangements of red carnation, red azaleas and greenery.

Mrs. Riley addressed the group in an informal discussion of Auxiliary problems.

The hostesses served a delicious dessert plate carrying out the valentine motif and presented a valentine corsage of red carnations to Mrs. Riley.

Mrs. George Wright, Secretary.

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75TH ANNUAL SESSION, LITTLE ROCK, APRIL 23-25, 1951

The Journal of the Arkansas Medical Society

Vol. XLVII FORT SMITH, ARKANSAS, APRIL, 1951 No. 11

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CARDIAC FUNCTION AND THE EMOTIONAL STATES*

LOUIS FAUGERES BISHOP, JR., M. D.
New York

I have chosen as my subject today, "Cardiac Function and the Emotional States." I might say as a personal reminiscence of the effect of the emotions on myself that I received in Arkansas one of the greatest emotional impacts that I have ever had, for it was in your state that I heard of the Japanese surrender . . . and the end of the war. I happened to have been at that moment living in a boarding house while I was working at the Army and Navy Hospital at Hot Springs . . . I won't go any further into what that emotional impact did to me—as you all, no doubt, did the same thing . . .

II. Definition

So much is being argued, written, and experimentally proved in psychosomatic medicine regarding cardiac function and the emotional states that before taking up various disorders affected by the emotions, I want to define as clearly as possible just what the modern concepts of the emotions really are.

I have not come across a better concept[1] than one advanced in 1949, and it ran something like this: Many pieces of the organic jigsaw puzzle of mental diseases are still missing, and in some instances the design only surmised. The conclusion is almost inescapable that all mental disorder, like other disease is the result of a disturbance in the normal physiology with resultant pathological processes, the whole doubtless influenced, as is the case in other fields of medicine, by disturbing environmental factors.

The foundation for this conclusion was laid by the studies of a number of earlier investigators such as Walter Cannon's report in 1915 on "Bodily Changes in Pain, Hunger, Fear, and Rage," closely followed in 1920 by Henry Head's "Studies in Neurology." Since then, many investigators have further elucidated this theme, particularly the role of the thalamus and the hypothalamus, in conjunction with the cortex, in explaining the basically organic nature of the emotions.

To be more specific, one might say that emotions[2] result from the action and reaction of the cerebral cortex and the diencephalon. The cerebral cortex is the immediate site of emotional consciousness.

Experimental work[2] has been done on certain emotional equivalents following lesions of the brain. Investigators have produced profoundly placid cats by removal of the neocortex, and they could also turn them into ferocious animals by adding later a lesion in the archicortex. By producing lesions in the archicortex and mesocortex, various workers have produced passivity, fearlessness, exaggerated affectionate behavior, marked oral reactions and excessive sex expression in monkeys. Sham rage has not been observed in monkeys or in man as the result of lesions. Possibly the difference in reaction between carnivora and primates is a species difference. The carnivora have need of a rage reaction in their hunting for food, whereas for a monkey rage at the time of his gregarious meal would be disorganizing.

III. What Are the Emotions?

Conceding the fact that the physiology of emotion, and the effect of the environment, are really the crux of the matter, it would seem that only on the basis of such knowledge can psychiatry obtain a well-rounded comprehension of the fundamental pathology of mental disorders which can lead to reliable methods of prevention and treatment.

What then are these emotions that affect function? The eight common emotions that cause physical illness in general are:

Need for love, approval and recognition; anxiety, fear and worry; inferiority feelings; ambivalence, a mixed emotion of love and hate; guilt; ambition or competition; and envy. While the need for love is a paramount emotional requirement, one might say that anxiety holds first place in disturbing cardiac function.

*Read before Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 17, 1950.

IV. Types of Cardiovascular Reaction; Methods of Response.

Many investigators[3] have shown that emotional disturbances may have a profound effect on the circulation, particularly on cardiac function because of changes in the heart rate, cardiac output, blood pressure, tone of peripheral vessels, and the electrocardiogram.

We are concerned for the most part with the general term, anxiety. Most workers agree that in the majority of persons anxiety has an effect on the circulation similar to that produced by a small dose of epinephrine: The cardiac output, the heart rate, and oxygen consumption are increased. There is a moderate elevation of blood pressure, but the peripheral resistance has decreased. The cardiac output is abnormally high in proportion to the rate of oxygen consumption. In certain subjects anxiety may be attended with circulatory collapse. In such cases, where peripheral resistance is decreased, the compensatory increase in cardiac output fails to occur, with a resultant fall of blood pressure to low levels.

From recent experimental studies[4,5] it has been observed that as part of the reaction to stressful life situations, such as associated with tension, frustration, conflict, anxiety, and depression, the cardiovascular apparatus may react with several types of responses. These may be of two kinds: a hyperdynamic and a hypodynamic response. These individual responses include alterations in the rate, rhythm, force, and magnitude of cardiac contraction, changes in the electrocardiogram, and modifications in the peripheral circulatory resistance. In a hyperdynamic circulatory reaction there is an increase in the cardiac output; in addition there may be a rise in blood pressure. In the hypodynamic reaction, less commonly observed than the hyperdynamic, an actual drop occurs in the cardiac output and blood pressure to levels below that of the initial, or resting state; this response has been elicited even in healthy subjects who have felt "let down" and betrayed.

V. The Relation of the Emotions to Certain Common Cardiovascular States.

The first of these I have selected is the cardiac arrhythmias with or without evidence of organic cardiovascular disease. Not only simple tachycardias may occur, but other types as well are affected by the emotions. In a recent report[6] the emotional state of the patient was found to be relevant to the occurrence of the arrhythmias, and they could produce extrasystoles experimentally during the discussion of topics to which these patients were known to be sensitive, or which previously had been associated with extrasystoles.

It would seem that the excitability of the heart may be significantly altered by prolonged hyperactivity of the cardiac muscle during anxiety, with resultant tachycardia and increased stroke volume; these experimentalists found this to be particularly true in structurally diseased hearts. It would seem that the observations made on extrasystoles would also hold true of other arrhythmias.

Case 1. A case in my own practice is a recent example of the effect of the emotions on a man without structural heart disease. The story of his initial attack was that it had occurred in a barber's chair during his being shaved. He quite suddenly became panicky and frightened. He felt that he was choking. He was sure that his heart was beating very fast. A physician was called who told the man that he might have a coronary thrombosis, or something very serious. He then went home, and called another physician. This doctor was not so sure about the coronary thrombosis. In fact, he told him exactly the opposite, that there was nothing the matter with his heart. Following this episode, a police surgeon saw him, and in view of the situation advised the man to stay in bed for several weeks. He did this, and when he got up he felt weak and jittery, and then proceeded to consult numerous other physicians: One would say he had heart trouble, another would say he did not. As a result he was completely confused as to what he had or did not have, and his anxiety became very much increased. And this had gone on for four years. He then went to a hospital where he received a thorough examination, and they felt that emotional anxiety was the basic diagnosis, and that there was no evidence of heart disease. He was satisfied that this was correct. So he returned to his police surgeon, and decided that he ought to try to work, but he has continued to have the attacks as described up to the present time.

There was no particular history of nervousness in his family. He is the oldest of six children, and started to work at the age of 14, and he does not describe his family as being of a nervous nature. He does not remember that he had any nervous attacks as a child. While his family was poor financially, as a boy his environment was a fairly happy one. He described himself as being very athletic in school, and he got along very well with his boyhood friends. He

was appointed to the Police Force at the age of 22, and has been on the Force for 23 years.

He married a few months before he went on the Police Force, and he had nine children, the oldest of whom is 23. It is interesting to note that the oldest boy, who was in the Navy for three years and saw considerable action in the Pacific, has very much the same symptoms as his father had, so much so that his father recognizes that these attacks are probably due to anxiety because they are so similar to what his son has who was under this prolonged nervous strain.

It is also interesting to hear that in view of this policeman's large family he had great difficulty in making ends meet, and states that even at this moment he has four or five loans in his pocket which he has had for a period of 12 years, for his salary is not enough to cover all his family expenses. So from time to time he gets in a considerable "hole." But his financial troubles have lasted so long that he does not feel that it is anything different than he has ever had.

He describes his wife as being somewhat "cranky," but no different than she has always been. After all, he has gotten along with her for a long time, so that he cannot see how this anxiety he has can be due to this part of his life situation.

His habits certainly are very good. He does not smoke. He does not drink, except occasionally he may have a few drinks when he meets a friend. His habits are scarcely abnormal. He has not taken any medicine in about two weeks although he felt at first that the medicine the last doctor gave him had helped; but it was only a temporary help, and now does not seem to relieve him. From the religious standpoint, he describes himself as being a fairly good Catholic. If his work does not interfere, he manages to go to church fairly regularly. He drives a radio car on the Police Force, and this does not wear him out particularly in any way, nor is it an usually prolonged strain. At the time I saw him recently he had been off on sick leave for two weeks.

Additional symptoms that came to light on further discussion were that this man had what is termed a "startle" reaction, saying that noises almost drive him crazy. He also had some phobias, such as, a fear of being in closed places, so much so that if he were, he had to get out and get some air. These symptoms have improved a good deal for he can now ride on a bus or trolly, but he "still has considerable difficulty with the subway" (which is interesting).

Several additional points that he brings up may be on an emotional basis. For example, he was very concerned about his boy during the years he was in the Pacific, and worried a great deal about his life. Another concern of his was worrying about one of his other children: This little girl had had convulsions the nature of which was somewhat obscure, and he was upset; but she was finally cured. No worry now about her. It is also interesting that his son now has somewhat the same type of thing as his father, and has had a recurrence of his symptoms lately. He himself is worried about this son who is planning to get married.

The man was referred to me as a specialist because his presenting symptoms are considered to be of a cardiovascular nature. This study was essentially negative. It is therefore obvious that the anxiety factors which are brought out by this history are of the utmost importance, and with no organic findings, treatment must be directed toward his emotional state.

Pain and the Emotions

We often see the effect of emotion on angina of effort,[7] presumably due to insufficiency of the circulation of the coronary arteries.

Pain is such a common complaint[8] so far as the cardiologist is concerned that it hardly seems necessary to reiterate to this audience the effect of the emotions on cardiac pain. For after the doctor has made his difficult and often almost impossible decision, whether the pain falls into the functional category (with its various synonyms), or whether the pain is a true angina of effort, with its basic lesion, coronary disease—the emotional problem is always present.

Because of the fact that in angina pectoris there is no known physical finding in X-ray picture or electrocardiogram which can tell you whether the patient has or has not pain of cardiac origin, in the last analysis, the diagnosis must always be based on the history alone. There is evidence that the reduction of oxygen supply to the heart muscle may be caused by narrowing or occlusion of the coronary arteries, or reduction of the caliber of the arteries through vasomotor reflexes. And there is strong evidence that vasomotor reflexes play an important part in the production of attacks at any given time; and it is well known that these reflexes may be initiated by strong emotional stimuli.[9] This could be illustrated by many of your own personal experiences.

Case 2. I have under my care at this time an Italian, 50 years old, who is subject to a rather classical anginal syndrome. Under ordinary circumstances, the pain brought on by exertion is completely relieved by nitroglycerine. But if at the same time that he is exerting himself he is under strong emotional strain (due to the fact that he is a cabinet worker and has to complete a given task to meet a deadline)—under these circumstances, nitroglycerine does not relieve his pain.

Case 3. Another illustration of such emotional influence on pain (with structural alteration), is a patient who has also an anginal condition. If he walks quietly, he has no symptoms. But if he walks, as he calls it, "in a business way," he can practically always produce an attack of pain which requires nitroglycerine for relief.

It has long been observed that an intense emotional situation can produce an immediate attack of angina. More recent studies point to the fact that man reacts not only to the actual existence of danger but to the threat and symbols of assault in his past which call forth reactions little different to those of the time of the assault. It would seem that so far as the care of a patient suffering from angina is concerned, a study of the life situation and of the emotional factors assumes deep importance. The functional or basic emotional problem is always present. I have under my care such an individual at this time with an interesting history.

VI. The Effect of the Emotions on Hypertension.

It is recognized by all clinicians that emotion plays a very large part in the hypertensive state. A recent very careful study [10] indicates that, in an analysis of the personality in hypertension, the existence of a high blood pressure is first observed in most of these cases within a year after the inception of the emotional disturbance; and in all of the cases, within three to eight years. In this series of cases the upheaval apparently continued to exert its influence throughout a long period.

It is well known that the exact date of onset of arterial hypertension is not easily established, and yet the synchronous occurrence of significant emotional disorders with the onset of hypertension in the series quoted [10] is very striking. A careful study of the emotional experiences in these cases would seem to point to a sudden loss of dependent security, with which was associated, or applied, an actual threat of death. This was not, or in any sense need be, a new occurrence, but in these particular patients similar patterns had occurred in the past. One emotional factor would seem to be common to all of these examples, and that is, loss of security and exposure to the aggression of the person on whom the person depended.

I think we should recognize the fact that arterial hypertension differs clinically from many of the diseases which have been investigated from the emotional standpoint: The disease is of an insidious onset. It may exist unknown to the person for some time before it has made itself manifest, or has been demonstrated by the sphygmomanometer. Hypertension is a general disease, involving an organ system of which the sufferer has no awareness. No patient ever complains of "high blood pressure." He may complain of the fact that he has been told that he is "suffering from high blood pressure," and he fears its consequences. It is more likely that he will complain of some such symptoms as headache, nervousness, irritability, or impairment of his feeling of efficiency.

Not only the patient but even his physician is sometimes in need of reassurance. For instance, a patient visited a spa for treatment. She related how a doctor there turned "green" when he read her blood pressure. She was asked, "Did you reassure him?" "I did," she replied.

In hypertension it is worth remembering that no matter how high the blood pressure values, of favorable significance are: A fairly normal-sized heart, nearly normal fundi, urine, and electrocardiogram. And these patients may go on for many decades much happier without frequent admonitions which only instill fear and unhappiness.

The marked variations seen in the offices of all clinicians is too well known to deserve comment. In my own experience, in the examination of boys for pilot training during the war, so characteristic was the rise in blood pressure, above the army regulations, that we preferred to characterize these boys with the letters "E A R"—which meant to us, "excessive aggressive reaction." If we had turned down for hypertension many boys who had a rise in blood pressure on examination, we would certainly have lost many fine pilots for our air force. Whether this type of blood pressure goes on later to develop a truly hypertensive state, I do not believe anyone can say.

VII. Neurocirculatory Asthenia.

The emotional state has been rather loosely used. In fact, the term, "aniety," has many con-

notations, yet it is recognized that other reactions occur, such as, resentment or anger, depending on the individual and the circumstances.

The impression that the so-called "effort syndrome" is a manifestation of the anxiety state has been strengthened during the last World War, although some cardiologists are not satisfied that it is entirely a psychosomatic manifestation. Undoubtedly, emotional stress is recognized as an important etiological factor. It is not uncommon to find the induction of symptoms through prolonged combat training, through suggestion by inference from doctors, or by warnings from relatives.

Case 5. In my own experience I have found the condition in at least one example [11] to be a specific response in one man twice repeated to the conditions of war.

The fluidity of this condition was well illustrated by this soldier examined during the last war. He presented a rather classical picture of this condition of neurocirculatory asthenia. When forced to separate him from the service, an interesting point came to light, that he had been separated from service in World War I for the same condition. From his history it had been learned that he had made a fair adjustment to his life as a farmer, but when faced with conditions in both wars, his symptoms were markedly aggravated. This condition may be difficult to detect in the routine examination of candidates for induction into the army. Not until faced with the physical and emotional strain of war does such a person with neurocirculatory asthenia become incapacitated.

Interestingly enough, another such case[12] was reported from England during the last war, as follows: "A corporal, aged 49, had had palpitation, dyspnoea, and precordial pain while serving with the German Army in the First Great War. The symptoms subsided at the end of the war. After experience of a concentration camp he developed an anxiety state, but he had no further symptoms referred to the heart until he entered the British Army during the present war. The symptoms of which he had complained in the first war then recurred, though his service employment was limited to the light work of a storeman, and he was considerably freer from physical and mental stress than he had been in Germany."

Although I have not recent figures, it is generally agreed that effort syndrome was less in the last World War than in 1914-1918. The reason for this I will not try to answer.

Recent studies[13] indicate that although a series of patients all had anxiety, so-called, they had not developed frequency to diseases of the heart. Yet recently cardiovascular disease has been considered to be caused by anxiety, and particularly hypertensive heart disease. This is also considered true of peptic ulcer, etc.

It is important to note that although neurocirculatory asthenia is usually a chronic disorder, in this series it does not interfere significantly with the person's work, social or family life, nor does it cause death. Often it becomes manifest, or is increased, when such a person is faced with hazardous undertakings, such as combat training for war, etc.

In general, in neurocirculatory asthenia, anxiety is usually present though not always in obvious form. And it is now well recognized that it can be modified by the life stresses of the individual. The improvement of the exercise tolerance in persons suffering from neurocirculatory asthenia, by means of psychotherapy, has been well studied, and is a definite observation.

VIII. Treatment.

We do not need elaborate instruments or tests to solve the many problems incident to the diagnosis and treatment of the emotional influences on cardiovascular disease. I do not in any sense mean to undervalue the various blood tests, metabolic studies, electrocardiography, roentgenography, angiocardiography, venous catheterization of the heart, or other examinations that may be necessary to a correct diagnosis before treatment can be established. And the advances in technical examinations that have taken place so rapidly have not been of purely academic interest. They have indeed enabled physicians, by the applications of new therapeutic procedures, both medical and surgical, to treat effectively, and at times to cure, certain persons previously thought to be beyond help. But it is still not uncommon to see a patient who has had a complete cardiac work-up, including the many technical procedures employed today, and at the same time find no evaluation made of the life situation of the patient.

Nevertheless, the emotional aspects of cardiovascular disease are incompletely studied unless adequate physical and laboratory tests are carried out. Thereby, the organic component may be as carefully evaluated as possible, no matter how minimal it may seem. And most important, reassurance of the patient is often impossible

without the operation of such technic. If disease is present it may be important to explain that the symptoms are out of proportion to what is found wrong, and that the explanation of these symptoms may well be on the basis of some emotionally disturbing events. Frequently, winning the confidence of the patient by showing interest in his problems and suffering, and by making him feel worth while, are all that is necessary. Or the advice of more work and useful endeavor, instead of rest, may be indicated, and result in dramatic improvement.

Before any help can be given the history must be carefully taken, and perhaps this is the most important step of all in understanding the effect of the emotions on cardiac function, a careful history.

A recent study[14] of the psychosomatic aspects of the cardiac arrhythmias, with a physiological dynamic approach, stresses the importance of a sympathetic attitude by the physician, and encouragement to the patient to tell his own story in his own way while not productive of an orderly history, and while time-consuming to the busy practitioner, has a great deal in its favor. It provides the means for the physician to see the patient's personality make-up, and gives insight into the possible functional nature of the ailment. Many of us[15] have had to learn a proper interviewing technic which we were not taught in our medical schooldays. Learning the proper history-taking for patients with functional heart disease will pay very large dividends. In reality, the confidence established in the physician by the patient, in that there is demonstrable interest in his case, together with a complete cardiac examination, and a simple explanation of the disturbance, — is psychotherapy — in its simplest form. A large number of patients respond to such management. All of us of course do run into cases where the emotional factor is so great that they cannot be helped by such ordinary procedures, and they may require careful analytic study, and should be referred to a specialist.

The use of drugs[15] should not be neglected in those patients in whom the cardiovascular functional aspects predominate. For example, in cardiac arrhythmias of psychogenic origin, during an acute episode of paroxysmal, auricular tachycardia or flutter, the emergency must be handled with drugs. One cannot expect psychotherapy to "break" such a paroxysm. While psychotherapy may be employed prophylactically, it is most helpful in handling the patient to resort to simple drugs to reduce the incidence of occurrence; this is particularly true of the cardiac arrhythmias. In any event, drugs used in the treatment of arrhythmias of psychogenic origin are similar to those used for cardiac irregularities arising from an organic basis.

In general, the treatment of both acute and chronic functional cardiovascular disease, where the etiology points to an emotional background, has been well summarized[16]: (1) Obtain and maintain the confidence of the patient. (2) Specific care of individual symptoms. (3) Reassurance of the patient. (4) Elimination and neutralization of the extrinsic factors. (5) And moral reorientation.

The psychosomatic concept[15] of disease in general in mankind is not new. From earliest times it has been known that the mind affects the body, as well as the body the mind. In recent years we begin to note the coming together of developments of various endeavors in the fields of classical cardiology, psychiatry, and physiology, with the idea of breaking down barriers in each field in its individualistic approach to the psychosomatic problem. The effect of the emotions on cardiac function will benefit by the unity of understanding thus achieved in the future.

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CORRESPONDENCE

March 19, 1951.

Dear Doctor Brooksher:

I am writing to thank the Arkansas Medical Society for its efforts during the recent legislative session on behalf of a new hospital for the University of Arkansas School of Medicine. I am sure that the action of the Assembly in making available funds which should permit the construction of a 400-bed hospital was in no small measure due to the active and vigorous efforts of the Society in presenting the needs of the school to the Assembly. I personally saw the tireless and unselfish work of many members of the Society, including its officers, its Legislative Committee and you and your staff. However, I know that hundreds of other members of the Society with whom I had no personal contact were equally helpful. At the public hearing before the Senate Committee on Revenue and Taxation the attendance of physicians from even the most distant sections of the State was really inspiring.

I hope that the new hospital facilities will help the school more effectively to serve the medical profession of the State and through them the people of Arkansas, and that we may continue to enjoy and to merit the support and cooperation of the Arkansas Medical Society in developing the policies of the School of Medicine.

Very sincerely yours,
Hayden C. Nicholson, M.D.,
Dean.

LOW SPINAL NUPERCAINE ANESTHESIA IN OBSTETRICS*

HERBERT E. SCHMITZ, M.D. and
JAMES B. FLANAGAN, M.D.
Chicago

Interest in the use of saddle block anesthesia in obstetrics has gained widespread popularity during the past several years. Our experience with this type of anesthesia has been previously reported in 1947[1] and 1949[2]. The suitability of this anesthetic for obstetrical cases makes it ideal, and hence it has become the anesthesia preferred on the obstetrical teaching service of the Stritch School of Medicine of Loyola University. The Lewis Memorial Maternity Hospital, Mercy Hospital, St. Vincent's Infant and Maternity Hospital and Misericordia Hospital are included in this service.

Material Studied

This study combines the previously reported series of 877 cases with a new group of 870 cases. In order that the study might be of statistical value, any marked variation between the two series will be indicated in the discussion of the combined total number of cases.

Technique

Nupercaine, the only anesthetic drug used in this study, is a complex amine derivation of quinoline. It forms hygroscopic crystals which are colorless, odorless, tasteless, readily soluble in water and alcohol, and makes a stable aqueous solution that may be repeatedly boiled without deterioration. Nupercaine in aqueous solution, however, is precipitated in the form of insoluble base by contact with the slightest amount of alkali. It is, therefore, advisable to rinse needles and syringes in a small amount of Nupercaine or weak HCl solution in order to guard against the accidental presence of alkali.

When the use of saddle block anesthesia was initiated, each patient was tested for sensitivity to the drug by intradermal injection or installation into the nostril. However, in view of the exceedingly low incidence of sensitivity, this practice has been discontinued except in cases giving a history of drug sensitivity.

The time of administration, with few exceptions, was the late first stage or the early second

*Department of Obstetrics & Gynecology
Stritch School of Medicine
Loyola University

Read before Seventy-eighth Annual Session, Arkansas Medical Society, Fort Smith, April 17, 1950.

stage of labor. This selection of time is purely arbitrary since rapidly progressing labor, particularly in the multipara, may warrant an earlier injection of the drug. In most of these instances the injection was made with the patient on the delivery table.

The skin is prepared with tincture of merthiolate, and the level of injection selected between the third and fourth lumbar interspace. A No. 22 or 20 needle is used to reduce the subsequent trauma and leakage of cerebrospinal fluid. The patient is placed in a sitting position for the intrathecal injection of 2.5 mgm. of heavy Nupercaine. The injection is made slowly between uterine contractions to minimize the dispersion of the drug and, after twenty-five seconds has elapsed, she is placed in the prone position with her head supported by pillows. With this technique anesthesia usually reaches the level of the umbilicus or slightly higher but without any obliteration of the motor control.

The blood pressure is taken before the injection and thereafter at two minute intervals until it becomes stabilized. All stimulants needed to combat vascular collapse are kept in readiness. In this series of cases repetition of injection was necessitated in only 38 cases of the combined total, and only once in the last series of 870 cases.

Contraindications

Utmost precaution to prevent any untoward effects from the use of this type of anesthesia is exerted. The incidence of complications can be controlled by recognizing the following contraindications:

1. Diseases of the cerebrospinal system and the spinal column.
2. Presence of pyogenic infection at or adjacent to the prospective site of puncture.
3. Poor condition of the patient: viz., shock, coma, sepsis and/or severe hypotension.
4. Obstetric complications such as placenta praevia, abruptio placenta, feto-pelvic disproportion and high position of presenting part.
5. Hypersensitivity to the drug.
6. Unfavorable types of patients: (1) Those suffering with chronic backache, headache or migraine. (2) Those desiring to be asleep at the time of delivery.

Results

All results of the procedure are based on subjective relief obtained by the patient. A patient who perceived some contraction pain after having had saddle block anesthesia was classed as being "incompletely relieved". "A failure" was one in which the patient may or may not have had some perineal anesthesia, but perceived no relief from the injection.

Figure I indicates the total number of cases in which saddle block anesthesia was employed—1747. Of this number 1662 or 95 percent had complete subjective relief for over one hour. 75 or 4.2 percent obtained incomplete relief and 10 or 0.5 percent were classed as failures.

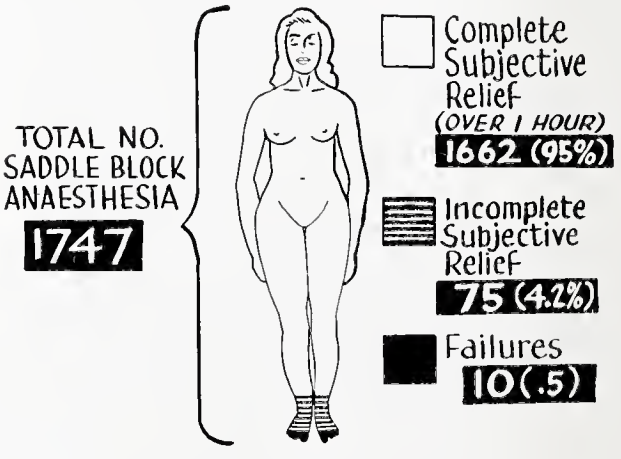
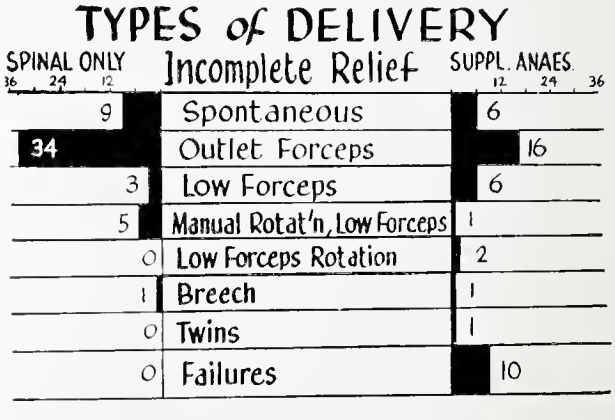
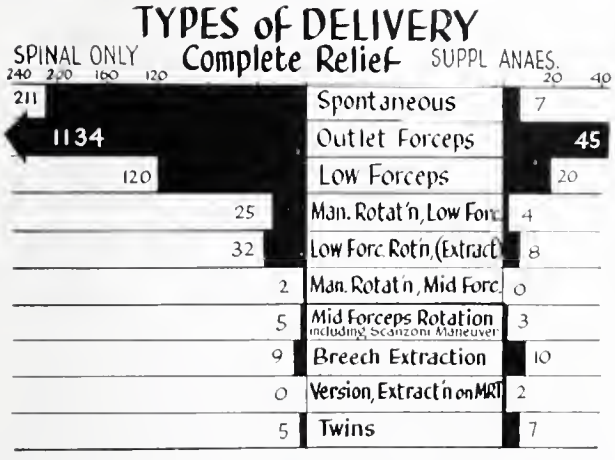


Figure II shows the proportion of patients who were delivered under spinal anesthesia only, both with complete and incomplete subjective relief, and those requiring supplementary anesthesia. This latter group is further classified as complete, incomplete or failure. A total of 1599 or 91 percent of all patients were delivered under spinal anesthesia only. Of these 1547 had complete relief and 52 incomplete relief. 148 patients, or 8.4 percent, required supplementary anesthesia because of such factors as (1) waning spinal effect in patients delivering later than one and one-half to two hours after administration of the anesthetic, and (2) to provide deeper anesthesia for such operative procedures as forceps rotation, breech decomposition, version and



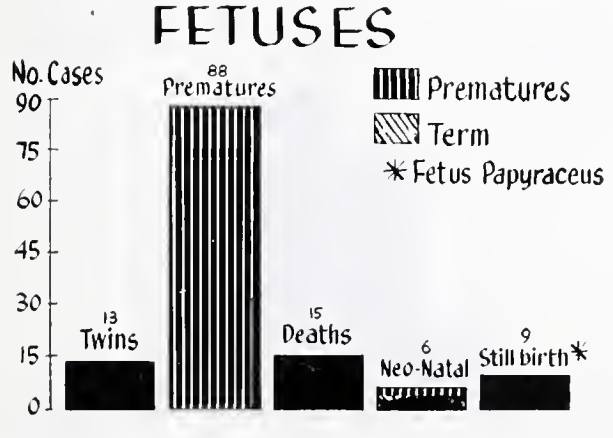
extraction, et cetera. In the initial series of this study, a number of patients were given supplementary anesthesia for psychological reasons, principally to relieve fear and apprehension, but in the last series this was done only rarely.

Indeed, a considerable number of patients in our clinic wished to be assured that saddle block anesthesia would be employed in their delivery.



These include patients who have had saddle block previously and those who have been told of its benefits. In general, subjective relief lasted for one to two hours, while objective relief or perineal anesthesia lasted usually in excess of three hours.

The manner of delivery is of considerable interest. In our earlier series 78 patients were delivered spontaneously, and in our later series 133 were so delivered, a total of 211, or an incidence of 12 percent of all deliveries. This serves to illustrate that the patient can utilize accessory forces to "bear down". This is accomplished by either the patient's own hand, or that of the obstetrician, on the abdomen to detect uterine contractions which the patient is incapable of feeling subjectively and with which she may effectively coordinate her "bearing down" effort. In our clinic, the use of prophylactic outlet forceps is routine and the majority of patients were delivered in this manner,



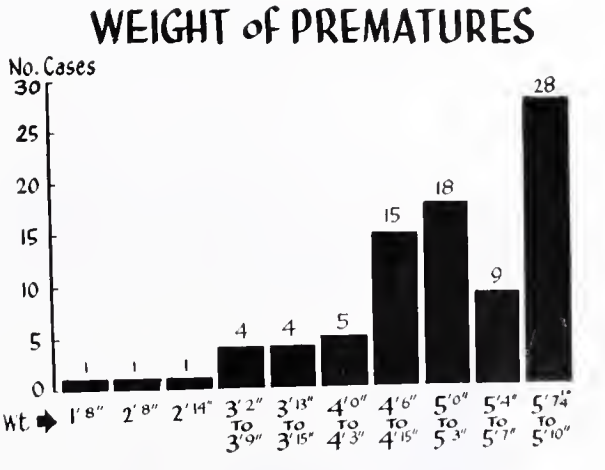
as can be seen by Figure III. The relatively great number of operative deliveries accomplished under saddle block without supplementary anesthesia is noteworthy.

Figure IV depicts the condition of the infants at birth. Any infant weighing 5 pounds 10 ounces, or less, has been arbitrarily grouped as "premature". Thus 88 premature infants were delivered, and the distribution of birth weights is shown in Table V. The fate of the first 44 premature infants could not be evaluated as the Chicago Board of Health Rules, set up by the American Committee on Maternal Welfare, required their transfer to hospitals with facilities for the care of prematures. Subsequently, however, Lewis Memorial Maternity Hospital was so equipped and the latter group could be followed. None of these infants were permitted to leave the hospital until a weight of 5 pounds was obtained.

UNTOWARD EFFECTS (Tot. Cases 1747)

	No. Cases	%
Untoward Weakness Slight to complete paralysis	1747	100
Effect on Blood Pressure Drop less than 20 mm. Hg --- " more " " " " ---	1301 446	25
Spinal Reaction (Sensitivity to drug?)	2	
Post Spinal Headaches	270	16
Neurological Complications (Foot drop)	3	

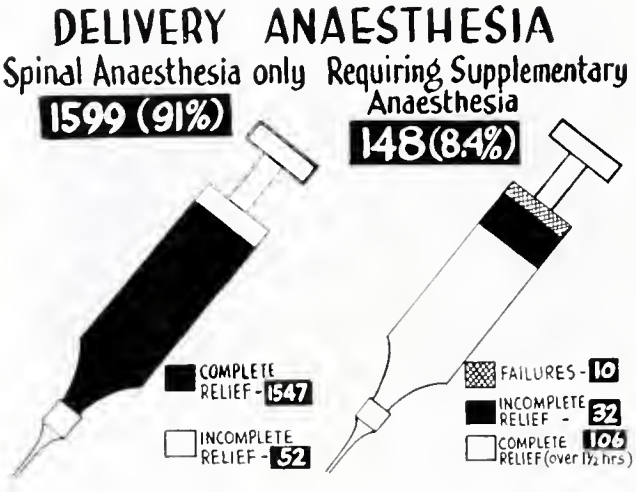
In our last series of 870 cases, there were 2 neo-natal deaths, one of which was due to congenital heart disease. There was a total of 6 neo-natal deaths in the combined series and 9



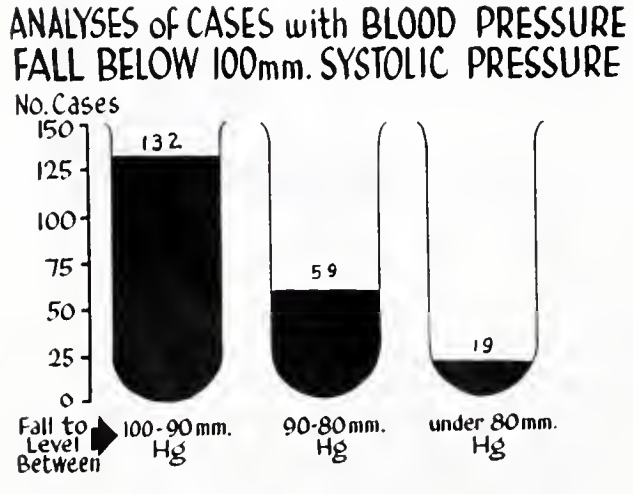
stillbirths. Of these stillbirths, 4 occurred in 4 sets of twins, one being a fetus papyraceous, 2 macerated and one apparently expired during the delivery of the second twin.

The untoward effects of saddle block anesthesia are illustrated in Table VI. Motor paralysis was present in 100 percent of cases listed as

completely or incompletely relieved; this paralysis varying from mild weakness to complete paralysis. These were all transient. As to neurological complications, there were 3 cases in the combined series, one a transient foot drop, the second a backache, which lasted for 4 days, and the third in a patient who had a partial paralysis and anesthesia of the left foot and leg which lasted for 4 days; this patient being delivered after a prolonged labor. The subject of blood pressure fall after saddle block anesthesia has received much attention. Table VI depicts an incidence of blood pressure fall in excess of 20 mm. of mercury in 23 percent of cases, yet in only 12 percent of cases did it fall below 100 mm. Hg. and in only 1 percent did it fall below 80. These latter figures are irrespective of the basal or pre-anesthetic blood pressure level.



In the initial series, ephedrine was injected prophylactically to all patients. In the latter series, however, this was done in only 35 percent of cases. The effect, as demonstrated in Table VII, is most notable in the fall of systolic pressure levels to between 90 and 100 mm. Hg. In the earlier report there were 39 cases in which the

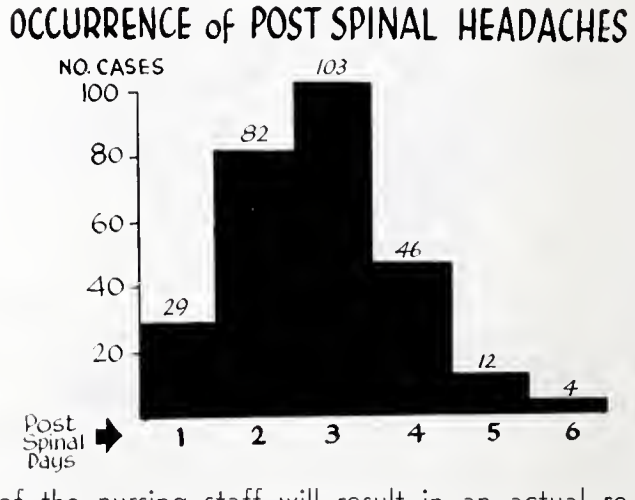


systolic pressure fell into this level, while in the latter series there were 93 such cases, yet this latter series had only **one** more case than the earlier series falling into the 80 to 90 mm. and the under 80 mm. levels respectively. Any significant fall in systolic blood pressure was readily combated by ephidrine (usually 3/8 gr. intramuscularly), elevation of the legs, oxygen and, in rare cases, intravenous fluids. A coincidental finding, not reported here statistically but of interest and actually a matter of common observation, has been the rapid rise in blood pressure following the emptying of the uterus of a hypotensive patient; the uterine contraction after delivery apparently providing the patient with an auto-transfusion.

The matter of postspinal headache has been of great concern. While all attempts to evaluate these necessitate using the subjective reactions of the patient, we have recently attempted to classify the postspinal headache into groups as follows:

1. Mild, but not incapacitating.
2. Moderate distress requiring analgesia, but not incapacitating.
3. Severe distress and incapacitating.

The first series did not classify headaches in this manner, but inasmuch as the latter series reported 17 per cent incidence of all headaches while the first series reported 14 percent, the classification in the first group could be expected to approximate that of the second. In the last 870 cases there was an incidence of 17 percent. 13 percent of this series had Group 1 headaches, 3 percent Group 2, and 1 percent Group 3. When the problem is considered from this viewpoint, it becomes a matter of less concern, and while it is believed that efforts should be continued to ascertain the cause and find satisfactory relief, we also feel that less pointed interrogation of the patient and proper instruction



of the nursing staff will result in an actual reduction in the incidence of this complication. The postspinal headache is unquestionably in

part "contageous"; i. e., one patient with an actual headache frequently is able to convince her fellow patients that they too can expect the same.

Therapeutically, numerous agents have been tried without consistent results. These include hypertonic intravenous glucose, anti-histaminics, ephidrine, prostigmin, caffeine sodium bengoate, as well as the usual analgesics. Table VIII illustrates the distribution of the days of appearance of the postspinal headaches. The majority appear on the third postpartum day, followed by the second and fourth days.

While saddle block anesthesia comes as close as any available to being the ideal analgesic agent for obstetrics, promising maximum safety for both mother and fetus, the fact that it is accompanied by some danger should be recognized; and hence, it should not be used by the inexperienced physician nor by an obstetrician who will not take cognizance of the potential danger and exercise all precautions.

It is indeed surprising that the neurological complications have been so few. Our cases of foot drop, a persistent backache and a partial paralysis and anesthesia of the leg, in three different cases, form only slightly over 0.1 percent of all cases, and all of these were transient. This low incidence was obtained in spite of the occurrence of bloody taps and instances where the patient complained of pain radiating into the leg at the time of the spinal puncture; situations which all of us have experienced.

The danger of drug sensitivity of both mother and infant needs no elaboration. We had one case of "spinal reaction" attributed to drug sensitivity, and in our second series we had one case of an acute psychotic attack and motor aphasia lasting twenty-five minutes. This patient had had a previous attack when given novocaine for dental work. There were no sequelae. Another patient developed a severe miningesmus subsequent to the appearance of a postspinal headache on the second postpartum day. Cultures of the spinal fluid were negative and the patient made an uneventful recovery.

The manifestations of a blood pressure fall is one of utmost importance. It is our practice to check the blood pressure immediately prior to injecting the nupercaine. Then again immediately after the patient is placed in a supine position, and subsequently at two to three minute intervals until the blood pressure reaches a level. While experience has taught us to anticipate some small blood pressure fall, we are very cognizant of the dangers of a severe hypotension, and we are at all times prepared to counteract it. Hingson[3] has pointed out that with maternal pressure remaining below 80 mm. Hg. systolic, fetal anoxia may be demonstrated in every case where this condition is allowed to exist for five minutes or longer. Failure to prevent or treat promptly the fall in blood pressure may result in irreparable damage to the fetus. **A live child does not signify an undamaged brain.**

Conclusion

There are many advantages of properly used saddle block anesthesia. For the fetus, spinal anesthesia provides maximum protection from two standpoints: (1) pharmacologically, the toxic drug reaction and the depression to the baby are absent, and (2) mechanically, the trauma to the fetal head is minimized by the elimination of involuntary "bearing down" reflex of the mother. The importance of this protection has been emphasized by Masters[4] of George Washington University School of Medicine in the delivery of premature infants.

The benefits to the laboring mother are obvious, and the nursing staff is appreciative of the absence of "last minute" confusion and excitement of imminent delivery.

From the obstetricians' viewpoint the advantages are many. It is the anesthetic of choice in cardiac patients, as well as patients suffering from respiratory diseases. The danger of the complication of aspiration and the additional narcotizing effect of supplementary delivery anesthesia in patients given heavy pre-delivery sedation is eliminated.

In our last series a patient was successfully delivered under saddle block anesthesia, although she had lobar pneumonia of the right middle and lower lobes on admission. The puerperium was complicated by thrombophlebitis developing on the fourth postpartum day, but which readily resolved; permitting discharge of the patient on the eighteenth postpartum day.

The use of saddle block in the second stage will eliminate most of the objections that the use of this anesthetic will increase the incidence of operative deliveries. We have previously noted the rather high incidence of operative deliveries. Dieckman[5] and his associates in their series of 719 cases have also noted no significant increase of operative deliveries.

In all, an experienced, qualified obstetrician can minimize the factors contributing to the potential dangers of saddle block anesthesia.

For such individuals, it provides the most nearly ideal form of obstetrical analgesia.

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OBITUARY

WILLIAM W. VERSER, age 76, Harrisburg, died March 17th. Born in Lonoke County in 1875, he graduated from the University of Tennessee College of Medicine in 1909 and had practiced at Haines, Brookland and Brighton before locating in Harrisburg 37 years ago. He was a member of the Masonic lodge and of the First Baptist Church. The Fifty-Year Pin of the Arkansas Medical Society was awarded him in 1949. He served two terms as a member of the State Medical Board of the Arkansas Medical Society and was its president during this period of service. He was a member of the Harrisburg School Board for 26 years and its president from 1942 to 1949. Two years ago he and his son, Dr. Joe Verser, erected the Verser Clinic Hospital at Harrisburg. Surviving are his wife, with whom he celebrated the golden wedding anniversary in 1950, a daughter, and a son, Dr. Joe Verser.

IN MEMORY OF DR. W. W. VERSER, HARRISBURG, ARKANSAS

A rare spirit has gone from us. His work is finished. No one was without hope when they had access to the ear and heart of Dr. Verser. No cause was lost that had him as its advocate. Heart and soul predominated in this good man so suddenly taken from his friends and loved ones and from the work he loved.

Up to the end he worried along with humanity same as always giving his services when needed. Finding a deep interest in the physical body and holding inviolate a confessional that touches the souls of men.

He was always prompt, always dependable as a physician and life saver, whom neither snow, nor heat, flood or gloom of night could stay from the swift completion of his appointed rounds.

To the family we can truly say—
There's an open gate at the end of the road
Through which each must go alone.
And there is a light we cannot see
Our Father claims His own.
Beyond this gate your loved one
Finds happiness and rest
And there is comfort in the thought
That a loving God knows best.

From friendly hearts that understand and share your grief with you.

Craighead-Poinsett Medical Society.

Whereas, an all-wise providence has seen fit to remove from our midst Dr. C. R. Gray, who was our valued co-worker and a faithful member of the Jackson County Medical Society, we the members of the society mourn and deeply regret his sudden departure.

Whereas, as a physician in his chosen field of surgery, he attained a great measure of distinction and won the respect of his colleagues, as well as the gratitude and love of a host of sorrowing people.

Wherefore, Be It Resolved, that the Jackson County Medical Society express to his family the esteem in which he was held as a member of the society and its heartfelt sympathy to the family at the untimely loss that they have sustained.

Be It Further Resolved, that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy sent to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Jackson County Medical Society by your committee.

John D. Ashley, Jr.

NEWS ITEM

A post graduate pediatric course will be given at the University of Arkansas School of Medicine, Little Rock, Arkansas, by the Pediatric Department, May 14 and 15, 1951. This is a course mainly for general practitioners.

Dr. Myron E. Wegman, of Louisiana State University Medical School, New Orleans, Louisiana; and Gilbert B. Forbes, M.D., of Southwestern Medical School, Dallas, Texas, will be the guest speakers.

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EDITORIAL

DOCTOR'S DAY

Through the untiring efforts of the Auxiliary and, in particular, to the activity of Mrs. Don W. Dykstra of Little Rock, the Arkansas Legislature passed S.C.R. 11 (Howell of Pulaski), as below, which established March 30th as Doctor's Day in Arkansas. So far as known, this is the first action by a state legislature to make Doctor's Day official.

"Whereas, our State and Nation owe a great debt to those unselfish physicians who labor long hours to care for our sick, and who are constantly engaged in research to prevent human misery and suffering, and

"Whereas, it is fitting that we should from time to time pay tribute to those unselfish individuals who guard the health of our Nation.

"Now, Therefore, Be It Resolved, by the Senate of the Fifty-eighth General Assembly, the House concurring therein, that the 30th day of March in each year is hereby designated and shall hereafter be known as, Doctor's Day in commemoration of the great sacrifices and untiring efforts and devotion of the members of the medical profession in performing their duty to humanity by caring for the sick and injured in times of individual need and during periods of pestilence, war, and other disasters and catastrophes.

"Be It Further Resolved, the Governor is authorized and requested to issue annually a proclamation calling upon all citizens of Arkansas to remember their physicians on that day and in some way to express their appreciation to these guardians of the Nation's health."

RANDOM THOUGHTS OF THE SECRETARY

February 21st. On a beautiful Ozarks day traveling north to Fayetteville, the streams running rapidly with ripples resplendent in the afternoon sun, the warmth of spring in the air and a glorious day to be out. Tonight Monfort visits bringing news of Independence county and its environs, his refreshing views on religion and medical practice, and thus cheerily ends a happy day.

March 10th. Appearing in the role of lecturer for the last time this scholastic year, a day no more welcomed by the audience than by the speaker, and then to discuss the projects and obligations of the medical society for the coming year with the President-Elect until plane time.

March 11th. Tonight comes President Hunt and the Mrs. a visiting and the talk is of the coming annual session and its mechanics with some casual remarks on the excellence of the Hunt grandchildren.

March 22nd. Comes President-Elect Henry for the evening and the talk comprises affair peculiar (sic) to medical organization and the whys and wherefores whereby enthusiasm and effort may be obtained from physicians in the interest of their field of endeavor.

THE AMERICAN MEDICAL EDUCATION FOUNDATION

Conceived as the answer of American physicians to the alternative of Federal subsidy for continuance of the American medical education system, the American Medical Education Foundation is widely heralded as the most important and constructive program ever undertaken by the medical profession. The ultimate success of the program lies with the individual physicians of America. The active, contributing support of the physicians of America is required.

The Board of Directors has asked that each county medical society appoint a committee whose effort will be to obtain contributions to the fund from the largest possible number of physicians on an annual basis. Such committees could first conduct a short campaign to inform the membership of the purposes of the Foundation, to be followed by an active solicitation to secure annual pledges for financial support of the Foundation.

It is hoped that component county medical societies will take steps at once to implement the purposes of the program. The Foundation must be a success; it cannot afford to fail.

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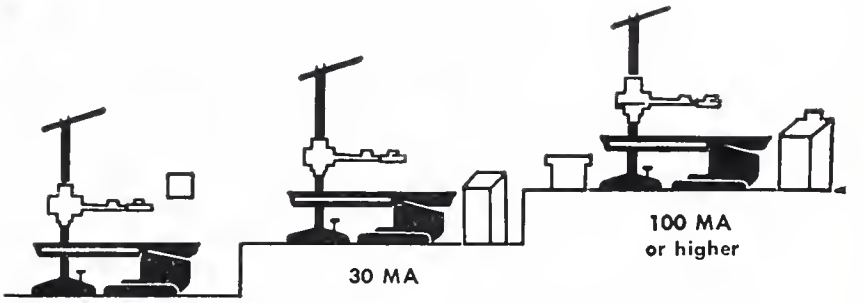
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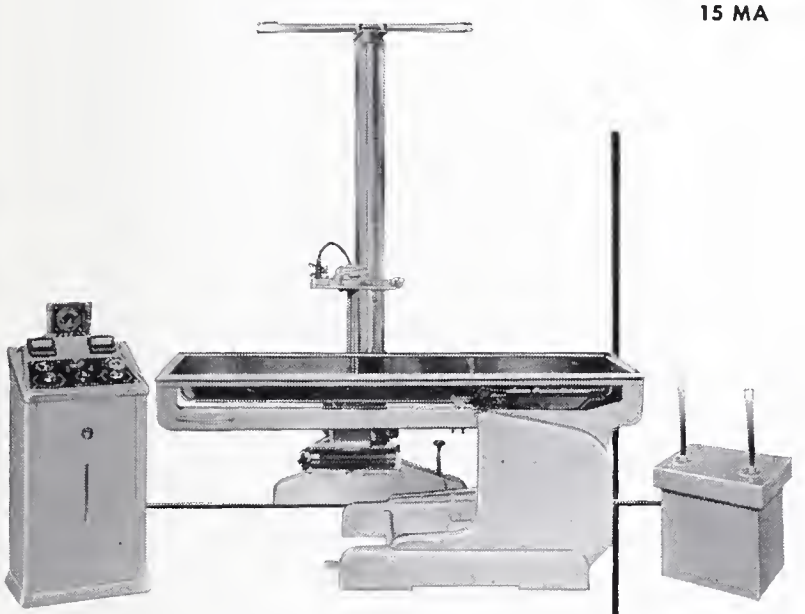
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TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

DROP IN TUBERCULOSIS DEATHS AMONG YOUNG PEOPLE CALLS FOR INCREASED EMPHASIS ON OLDER AGE GROUPS

Mary Dempsey, Statistician, National Tuberculosis Association, The NTA Bulletin, October, 1950.

The control of a disease like the waging of a war depends for success upon knowledge of the enemy, where he is to be found and in what numbers. This knowledge about tuberculosis is to be found in an analysis of the death rates from the disease. Tuberculosis control programs which ignore the implications of the changing character of tuberculosis mortality are missing the golden opportunity now at hand to eradicate the disease.

During 1948, the actual number of deaths from tuberculosis in the United States was 43,833, a decrease of 8.8 per cent when compared with 1947. These final figures compiled by the National Office of Vital Statistics in Washington are published in Public Health Reports for April 7, 1950.

When age groups are considered, however, the decline in the number of deaths is extremely uneven. For example, tuberculosis deaths among young persons 15 to 24 dropped 26.2 per cent between 1947 and 1948, while among elderly persons 65 years of age and over there was an actual increase of 0.5 per cent (one-half of one per cent).

During the past decade the decline in the number of tuberculosis deaths among those 15 to 24 was by no means comparable with the drop between 1947 and 1948. The almost steady increase in the percentage of decline in the deaths among those in this age group appears in the following table.

Table 1

Percentage decline from one year to the next in the number of tuberculosis deaths among persons 15 to 24 years of age: United States, 1939-1948

Years	Percentage decline in the number of tuberculosis deaths among persons 15 to 24 years of age
1947-1948	26.2
1946-1947	12.1
1945-1946	10.4
1944-1945	7.7
1943-1944	7.7
1942-1943	4.5
1941-1942	5.6
1940-1941	3.5
1939-1940	2.8

The probable explanation of this extraordinary drop in the 15 to 24 year age group is that in this country young people of today are exposed to much less tuberculous infection than was the case a few decades ago. It is likewise probable that most young people have increased resistance. A third theory might be that those in the younger adult groups have become somewhat health conscious as the result of long-continued health education programs. Yet it is difficult to account for such a pronounced difference in very recent years. During the five-year period, from 1937 to 1942, tuberculosis deaths in this one age group (15 to 24 years) dropped 24.9 per cent, less than the percentage decline in one year between 1947 and 1948.

Analysis of the number of tuberculosis deaths in each age group between 1947 and 1948 presents more complete information on this subject.

Table 2

Percentage increase or decrease in actual number of tuberculosis deaths, classified by age group: United States, 1947 and 1948

Age group	Deaths from tuberculosis 1948	1947	Percentage increase or decrease 1947-1948
All ages	43,833	48,064	— 8.8
Under 15 years	1,636	1,698	— 3.7
15-24 years	3,933	5,332	—26.2
25-34 years	6,591	7,697	—14.4
35-44 years	7,573	8,314	— 8.9
45-54 years	8,165	8,865	— 7.9
55-64 years	7,737	7,999	— 3.3
65 years and over	8,168	8,130	+ 0.5
Age unknown	30	29	+ 3.4

Surprisingly enough, deaths among children under 15 years of age dropped very little, though the numbers involved are small. Beginning with the group 15 to 24 years old, the decline is very pronounced and becomes less so with each succeeding age group. Few compilations point out so strongly the increasing concentration of tuberculosis deaths among older people.

Another comparison of interest has to do with the decline in the actual number of deaths according to sex. In spite of the fact that deaths among males are nearly twice as numerous as among females, deaths among the former are

Table 3

Percentage decrease in actual number of tuberculosis deaths, classified by sex and color: United States, 1947 and 1948

Sex and color	Deaths from tuberculosis 1948	1947	Percentage decrease 1947-1948
Total	43,833	48,064	8.8
Male	28,552	30,585	6.6
Female	15,281	17,479	12.6
White	31,750	34,783	8.7
Male	21,616	23,167	6.7
Female	10,134	11,616	12.8
Non-white	12,083	13,281	9.0
Male	6,936	7,418	6.5
Female	5,147	5,863	12.2

nevertheless declining at a much slower rate. This statement is true whether one considers white people only or non-whites (See Table 3).

These findings conform to the long-held impression that tuberculosis becomes increasingly a disease of men and particularly of older men.

Careful study of these mortality data points first to outstanding achievements of the many agencies (both official and voluntary) which have for so long waged war against tuberculosis, and second to those areas of activity in which success has been much less marked. It is evident that more concentrated efforts must be directed toward control and ultimate eradication of the disease among men, among older people, and among non-white people if the total program is to continue to be as successful as it has been in the past.

Table 4

Percentage decrease in actual number of tuberculosis deaths, classified by form of disease: United States, 1947 and 1948

Form of disease	Deaths from tuberculosis 1948	1947	Percentage decrease 1947-1948
All forms	43,833	48,064	8.8
Pulmonary	40,420	44,462	9.1
Other forms	3,413	3,602	5.2

Inasmuch as the actual number of deaths is used in each instance—and not death rates—it is obvious that the great increase in the country's population has not been taken into consideration. Inclusion of this factor would serve to accentuate rather than to minimize the declines noted.

ANNUAL MEETING
of the
ARKANSAS ACADEMY OF GENERAL PRACTICE

April 22, 1951

Continental Room — Marion Hotel — Little Rock

2:00 P. M.

Call to Order ..... President McDaniel
Reading of Minutes .....
Report of Secretary .....
Report of Delegates ..... R. B. Robins, Camden
The Future of the "GP" ..... Walter C. Alvarez, Editor, "GP", Chicago
Introduced by R. B. Robins
"Society's Challenge to Modern Medicine" ..... John R. Bender, Sec., North Carolina Academy of General Practice, Winston-Salem
Introduced by C. Randolph Ellis, Malvern
"The Acute Abdomen" ..... Phil Thorek, M.D., Chicago
Presentation of Gavel ..... R. B. Robins, Camden
Report of Nominating Committee .....
Election of Officers .....
Business Session .....

BANQUET

Continental Room — Marion Hotel — Little Rock

6:30 P. M.

Music ..... Marked Tree Ensemble
President's Address ..... L. H. McDaniel, Tyronza
Address ..... "The Anatomy of the Funny Bone"
Mr. Charles Evans, Director of Public Relations, Arkansas Power & Light Co., Little Rock
Introduced by M. D. McClain, President-Elect, Arkansas Academy of General Practice, Little Rock
Presentation of President-Elect .....
Installation of Officers for 1951 .....
Adjournment: Sine Die .....

PULASKI COUNTY MEDICAL ASSISTANTS ASSOCIATION

By Miss Charlene Hardeman, Publicity Chairman

It all happened in April, 1949, when the physicians of Pulaski County decided that the time had come when their office personnel should be formally and correctly informed about the impending dangers of socialism into medicine. Many interested office technicians, medical secretaries, bookkeepers, and nurses congregated for this meeting. But they, too, had an idea.

Over their coffee cups before office hours, these women had begun to realize that this medical assistant or that secretary was having a reception-room courtesy fault, a difficult collection problem, some hindrance to office efficiency and many other general medical office problems which could bear group discussion without violating office confidences. They had a real need and desire for group discussion.

The Pulaski County Medical Assistants Association was born. Their aims are to study medical economics, stay abreast of medical trends, strive to improve their medical public relations and also to provide a modicum of social activities for medical office personnel. They are making progress in their goals.

Mrs. E'za Lee Dunn, secretary to Dr. Marion Craig, set a high standard of leadership as the Association's first president. She presented a widely varied program for 1949 and 1950 to learn what subjects were most needed by medical assistants.

Mrs. Marguerite Broderick, secretary to Dr. Charles R. Henry and Dr. Robert W. Ross, is the 1950-1951 president. She is achieving her aim this year by obtaining a much needed course in medical education available to all members, and others in the medical profession.

Other officers for this year deserve much credit for their work toward the betterment of courtesy, efficiency and understanding by women working in a doctor's office or allied medical offices. They are: Mrs. Katherine Beaty, secretary to Dr. Joe Shuffield, vice-president; Mrs. Irene Haney, secretary to Dr. John Laman, treasurer; Miss Nan Williams, secretary to Dr. M. J. Kilbury, recording secretary, and Mrs. Lella Mae Merck, secretary to Dr. Deane Wallace, corresponding secretary.

1949-1950 PROGRAM

July, 1949—"Collection Notes & Letters"—Mr. Gaston Fulmer, Physicians Business Bureau.

August—"The Blue Cross-Blue Shield Program"—Mr. William Temple, Blue Cross-Blue Shield.

September—"Expediting Insurance Claims for Your Patient", Mr. Russell H. Feild, Claim Adjuster.

October—"Resume of Good Public Relations Needed in Medical Offices", Mrs. Mason Lawson, 4th Vice-President, Auxiliary to American Medical Association.

November—Round-table discussion: "The Telephone—the Best Mode of Collection", Mrs. Rhea Watkins, a credit manager; Mrs. Marie Freemyer, collector for physicians; Mrs. Norma Gaston, moderator (office manager for Drs. Rhinehart.)

December—"Watch Your Medical Ethics", Dr. M. J. Kilbury.

January, 1950—"You and Your Boss", Dr. Daniel Autry, President, Pulaski County Medical Society.

February—"H-R 6000", Mr. Eugene Warren, Attorney, Arkansas Medical Society.

March—"By Jupiter", courtesy film, Miss Fentem Utley, State Health Department.

April—"Quiz on Ordinary Medical Terms and Pronunciation", jam session among the members.

May—"Road Ahead", book review, Mrs. Charles R. Henry, Auxiliary to Arkansas Medical Society.

June—Picnic.

July—A demonstration of various drapings of patients, by members in different specialty offices.

August—"Red Cross Nurses Aid Training Course", Mrs. John Pruniski, Chairman.

(Two members appeared with two doctors' wives before the Auxiliary in a **closed** round-table discussion, "The Secretary Meets the Doctor's Wife." This program was a huge success because the participants were hand-picked and displayed the nth degree of tact and diplomacy. Each went home determined to improve in her role in her relationship with the doctor. Two doctors sat in on this discussion.)

Charlene Hardeman,
Publicity Chairman.

THE ANNUAL MEETING

The preliminary program and announcements of the coming annual session of the Society to be held at the Marion Hotel, Little Rock, April 23rd, 24th and 25th, were published in the March issue of The Journal. Members are requested to refer to this issue and delegates are asked to bring this copy with them to sessions of the House of Delegates as it contains the committee reports which will not be read.

The Committee on Scientific Work has tirelessly endeavored to present a program of interest and profit to all the membership. Of particular interest will be the sectional meetings on pediatrics and on obstetrics and gynecology to be separately held the afternoon of April 24th. These will follow a combined symposium on these

three subjects to be held in the morning period. The customary sectional meeting of the eye, ear, nose and throat group will be held Tuesday morning. Distinguished guest speakers will address all sessions.

The 1951 meeting promises to offer much in scientific value to all members in addition to its opportunity for friends to meet in both formal and informal social gatherings. Formal social gatherings will include the annual banquet to be held Tuesday evening, the past-president's breakfast to be held Wednesday morning and the Fifty-Year Club breakfast to be held Tuesday morning.

All activities will be held at the Marion Hotel. Reservations should be made in advance.

NEW ANTITHYROID COMPOUND FOUND MORE EFFECTIVE

A new chemical has been reported to be fully and rapidly effective in hyperthyroidism, including those cases which have not responded to previous antithyroid therapy.

This compound, 1-methyl-2-mercaptoimidazole, differs in structure from the thiouracils. Initial doses of 15 to 30 mg. daily, divided into three doses at eight-hour intervals, should be continued only until symptoms are controlled; thereafter, hypothyroidism is avoided by reducing the amount to the maintenance level of 5 to 15 mg. daily in divided doses. Since the possibility of producing agranulocytosis does exist with any antithyroid drug, it is advisable to run routine differential and white-blood-cell counts every week to 10 days.

This drug is now marketed in 5-mg. tablets under the name "Tapazole" (Methimazole, Lilly).

RESOLUTIONS

Whereas, an all-wise providence, has removed from our midst, Dr. John Watkins, who was our valued co-worker and a faithful member of the Pulaski County Medical Society, we the members of the society mourn and regret his sudden departure.

Whereas, as a physician in the field of ophthalmology and otolaryngology he rendered great service to the public and won distinction in this field, and the respect of his colleagues.

Therefore, Be It Resolved, that the Pulaski County Medical Society express to his family this token of the esteem in which he was held by the members of the society, and express its heartfelt sympathy to the family at the untimely loss which the Society has sustained.

Be It Further Resolved, that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy sent to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

Robert Caldwell,
R. A. Law,
L. F. Barrier.

THE ANNUAL SESSION

The Arkansas Medical Society will meet at the Marion Hotel, Little Rock, Monday, Tuesday and Wednesday, April 23rd, 24th and 25th. The scientific program and preliminary announcements were published in the March issue of The Journal as were reports of committees to be presented to the House of Delegates. Members are advised to make hotel reservations now.



PERSONALS AND NEWS ITEMS

D. W. Goldstein, Fort Smith, addressed the Sebastian County Dental Society February 26th on "Lesions of the Oral Mucosa."

Howard Schwander and Lawrence Zell, Little Rock, conducted a diagnostic cancer clinic at Conway recently under the joint auspices of the Faulkner County Medical Society and the Arkansas Division, American Cancer Society.

L. E. Drewrey, Camden, attended the recent meeting of the National Association of Methodist Hospitals at Chicago.

Fount Richardson, Fayetteville, has been named a member of the joint committee on industrial health of the American Medical Association and the American Academy of General Practice.

James W. Headstream, Little Rock, recently became a diplomate of the American Board of Urology and is now head of the Division of Urology in the Department of Surgery at the University of Arkansas School of Medicine.

R. B. Robins, Camden, appeared as banquet speaker at the annual meeting of the North Carolina Academy of General Practice, Durham, N. C., on March 6th.

Mason G. Lawson has been appointed Acting City Health Officer at Little Rock.

A. A. Blair has been elected treasurer of the Superior Federal Savings and Loan Association at Fort Smith.

D. W. Goldstein, Fort Smith, attended the recent meeting of the Louisiana Dermatological Society at New Orleans.

F. J. Scully recently addressed the Hot Springs Lions Club on travel conditions in Europe.

"Thyroid Deficiency in Childhood" by W. A. Reilly, Little Rock, appeared in the Southern Medical Journal for March, 1951.

C. C. Long, Ozark, has been elected chief of staff of the Clarksville Municipal Hospital.

"Pneumoencephalographic Changes Following Prefrontal Leukotomy, Freeman-Watts Technic" by Isadore Meschan and Joe B. Scruggs, Little Rock, appeared in The American Medical Association Archives of Neurology and Psychiatry for January, 1951.

J. H. Pinson has been elected surgeon of the El Dorado post, Veterans of Foreign Wars.

R. B. Robins, Camden, has been elected president-elect of the American Academy of General Practice.

Friedman Sisco, Springdale, has been elected a director of the Mutual Insurance Company.

PROCEEDINGS OF SOCIETIES

The Pulaski County Medical Society met March 5th with Benjamin B. Wells serving as moderator for a roundtable discussion on headaches.

Edwin F. Gray, Secretary.

Ouachita County Medical Society was entertained with a buffet dinner by C. R. Graham of Camden, a Navy physician, at the Officers' Club of the Naval Ammunition Depot, Camden, on March 1st. The following scientific program was heard: "The Red Cross Blood Bank Program," M. J. Kilbury; "Differential Diagnosis Between Pulmonary and Cardiac Conditions," J. N. Compton and "ACTH and Cortisone," R. D. Lowrey, all of Little Rock, and "Medical Conditions in Defense Plant Workers," C. R. Graham, Camden.

The Sebastian County Medical Society met March 13th with J. Frank Blakemore, D.D.S., as speaker on "Fluorination of City Water Supply." J. W. Amis and D. W. Goldstein were elected delegates and T. P. Foltz and Carl L. Wilson were elected alternates.

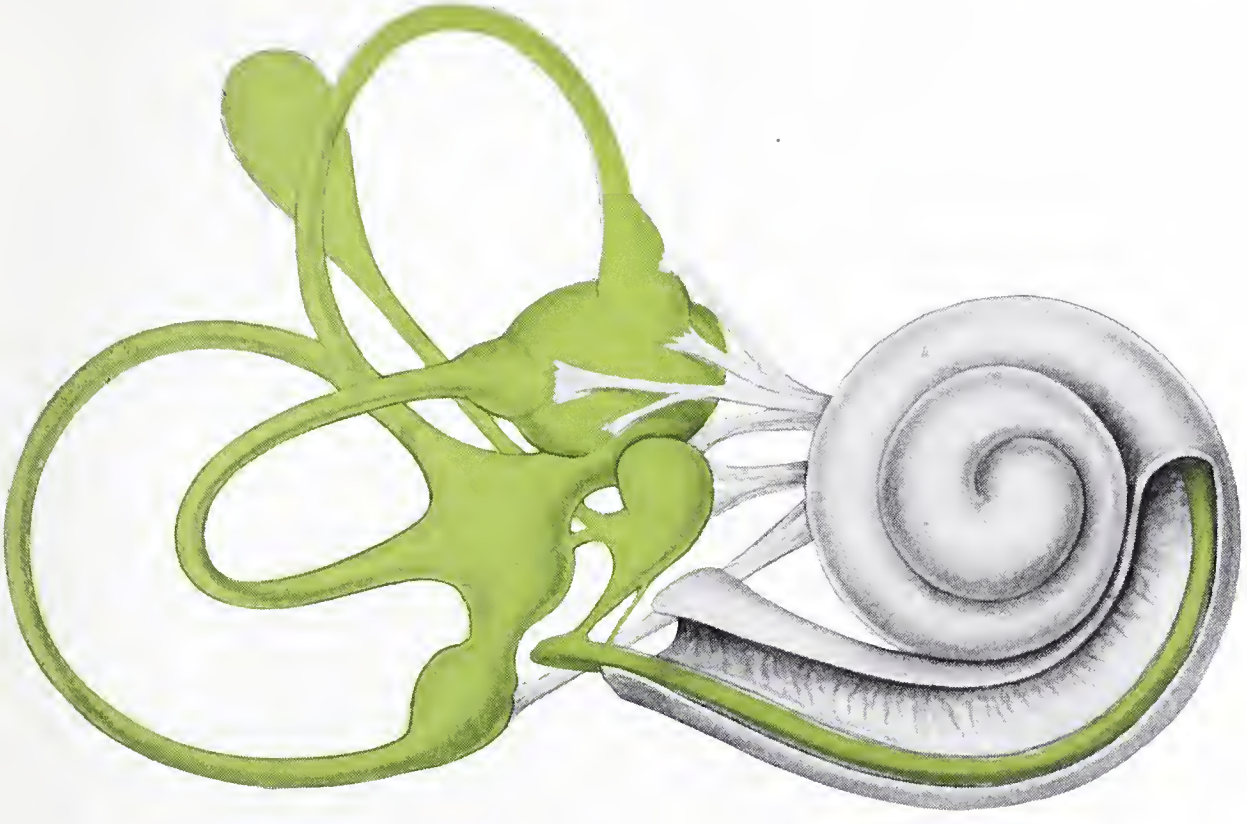
Art B. Martin, Secretary.

Craighead-Poinsett County Medical Society met at Jonesboro March 7th with the following scientific program: "Acute Bleeding from the Upper Intestinal Tract: The Viewpoint of the Surgeon, Internist, Radiologist and the Pathologist"; George Coors, Howard A. Boone, Edward Mabry and W. W. Tribby, all of Memphis.

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Pulaski County Medical Society will meet at 12:00 noon, March 21, at the Y.W.C.A. with Mrs. T. D. Brown, President, officiating.

Dr. W. G. Cooper, Jr. will speak on the Cancer Control Program and Mrs. Gordon P.



Detail of the Labyrinthine Structure

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—Tuttle, A. D.: Special Breakdown of Case Histories, presented at the Airlines Medical Directors Association Meeting, New York, N. Y., Aug. 28, 1949.

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RESEARCH IN THE SERVICE OF MEDICINE SEARLE

THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

Oates will show the film "Breast Cancer". The Executive Secretary of the Pulaski County Cancer Society, Mrs. Margie Bartlett, will be a guest.

Hostesses will be Mrs. W. J. Schwartz, Mrs. Ewell Thompson, Mrs. Dan Autry, Mrs. Phillip Cullen, Mrs. Gilbert Dean and Mrs. Ellery Gay.

Mrs. Alfred Kahn, Jr.,
Publicity Secretary.

The Pope-Yell County Medical Auxiliary met Thursday evening, March 8, in the home of Mrs. Max J. Mobley, with seven members present. Mrs. Martin F. Heidgew joined our Auxiliary as a new member. The meeting was presided over by Mrs. William O. Young, Jr., President. After minutes of our February meeting were read and approved, new officers for 1951-52 were elected as follows:

Mrs. Max Mobley, President; Mrs. Brooks Teeter, Vice-President; and Mrs. William Henry, Secretary-Treasurer.

Mrs. Roy Millard reported that our Biography of a local doctor had been completed and mailed to the State Chairman. It was voted that we send a contribution to the Martha Harding Gann Memorial Loan Fund. Mrs. Roy Millard was appointed to make a talk to the local high school assembly on "Nurse Recruitment."

Discussion followed on plans for attending the State Medical Meeting in Little Rock in April. Our delegates will be elected at our April meeting.

Mrs. Max Mobley.

The Woman's Auxiliary to the Pulaski Medical Society met Wednesday, February 21, in the Y.W.C.A. with Mrs. T. D. Brown, President, officiating.

Mrs. James Headstream, Mrs. Drew Agar, Mrs. Frank Kumpuris and Mrs. John Brizzolara presented a skit, "The Doctor Takes a Wife."

Hostesses were Mrs. Joseph Calhoun, Mrs. Grady Reagan, Mrs. Curtis Jones, Sr., Mrs. Curtis Jones, Jr., Mrs. Elvin Shuffield and Mrs. James Newbill.

Mrs. Alfred Kahn, Jr.,
Publicity Secretary.

The Union County Medical Auxiliary met March 7 in the Club Room of the Randolph Hotel. Hostesses were Mrs. Gardner Landers, Mrs. Frank Clark, and Mrs. Albert Clowney. Twelve members and two guests, Mrs. Warren S. Riley, State President, and Mrs. Mason Lawson, 3rd Vice-President of the National Medical Auxiliary, were present.

The Nominating Committee presented the following slate of officers for the coming year:

Mrs. J. H. Pinson, President.
Mrs. Gardner Landers, Vice-President.
Mrs. Schuler McKinney, Recording Secretary.
Mrs. L. E. Fitch, Corresponding Secretary.

Mrs. Paul Henley, President, presided over the business meeting. Mrs. Riley and Mrs. Lawson gave brief talks and Mrs. Fitch reported on current legislation.

Mrs. James Oliver Cooper,
Corresponding Secretary.

Outstanding spring fashions were featured in the fifth annual style show presented Saturday afternoon at the Hotel Pines by the Woman's Auxiliary to the Jefferson County Medical Society, before a capacity audience of 400.

Plans for the affair were in charge of Mrs. Howard S. Stern, general chairman, and the following committee chairmen:

Fashion Show—Mrs. Arthur Fowler, Jr.; Project—Mrs. Charles W. Reid; Door Prize—Mrs. Allen R. Russell; Publicity—Mrs. T. J. Cunningham, Jr.; Decorations—Mrs. Ross Maynard; Arrangements—Mrs. Fred Hames; Food—Mrs. R. D. Dickens; Tea Tables—Mrs. Louis K. Hundley; Hospitality—Mrs. J. S. Spillyards; Tickets—Mrs. George B. Talbot and Mrs. Sanford C. Monroe.

Mrs. Mason G. Lawson, National Vice-President; Mrs. Warren S. Riley, State President; Mrs. J. G. Martindale, President-Elect of the State Auxiliary; and Mrs. Ben Means, 2nd Vice-President of Pulaski County Medical Auxiliary assisted Mrs. Gordon Oates, 1st Vice-President, in organizing Clark County Medical Auxiliary with 10 charter members. The following were elected officers:

President, Mrs. Jack Kennedy, of Arkadelphia; Vice-President, Mrs. Charles Clark, of Arkadelphia; Secretary, Mrs. Wallis Ross, also of Arkadelphia; Treasurer, Mrs. A. W. Thompson, of Gurdon.

The Monroe County Medical Auxiliary held its regular meeting on February 21 with a luncheon in the home of the President, Mrs. E. D. McKnight, Brinkley.

Mrs. Warren S. Riley, President of the State Medical Auxiliary to the Arkansas Medical Society, was an honor guest and talked on the work of the state organizations, and annual meeting to be held in April in Little Rock.

The election of county officers will be held at the March meeting.

Mrs. E. D. McKnight, Pres.
Mrs. M. L. Dalton, Sec'y.

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The Journal of the Arkansas Medical Society

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ARKANSAS DIVISION

314 Professional Building

FORT SMITH, ARKANSAS

American Cancer Society

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THE USE OF ANTICOAGULANTS IN DISEASES OF THE CIRCULATION*

CHAS. T. CHAMBERLAIN, M.D.
Fort Smith

It has been my privilege in the recent past, as a member of the Heart Committee of this Society, to present to you through the medium of the Journal and with the permission of the American Heart Association, summaries of current diagnostic and therapeutic problems in diseases of the circulation. Today, and quite informally, I wish to summarize for you pertinent data having to do with the use of the anticoagulants in the prevention of thrombo-embolic phenomena in diseases of the heart and the peripheral circulation.

This symposium today is, I feel, appropriate chiefly in the sense that 1950 represents the inaugural year for the Arkansas Heart Association as an incorporated subsidiary of the American Heart Association, and in the sense that for the first time this year the Arkansas Heart Association has just completed a heartening campaign of publicity and solicitation of funds in a number of counties throughout the State.

Original observations are made and recorded mentally, and sometimes in writing, each day by the individual physician in the clinic, at the bedside, in the laboratory, and at the autopsy table. From the standpoint of statistical value, these observations and conclusions, while stimulating to him, are relatively useless unless the opportunity is present to make such data significantly and accurately voluminous quantitatively or statistically. Consequently, for guidance the physician turns to reports of case studies in the literature conducted by clinical research groups who have facilities for controlled studies under conditions where the volume of material becomes significant.

In 1946 the American Heart Association formed a committee for the evaluation of anticoagulants in the treatment of myocardial infarction. "One thousand-thirty-one cases of coronary occlusion and myocardial infarction were studied under the conditions of this particular investigation. Conventional methods of therapy alone were employed in slightly less than half of these cases. In the others anticoagulants were used in addition to conventional methods of treatment. Four hundred forty-two patients received conventional therapy and constituted "the control group." Five hundred eighty-nine patients received anticoagulants in addition to conventional therapy and constituted "the treated group."

The principles used in the administration of dicumarol and heparin during this study were as follows: (1) Heparin may be given for the first forty-eight hours or more if desired, 200 mgs. intramuscularly every four hours. (2) Prothrombin determinations are to be done each day and no dicumarol should ever be ordered unless the daily prothrombin report is available. (3) Dicumarol, 200 to 300 mgs. daily, should be given until the prothrombin time is 30 seconds. (4) Dicumarol, 50 to 100 mgs. daily, should be given if the prothrombin time is between 30 and 35 seconds. (5) Dicumarol should be withheld if the prothrombin time is 35 seconds or more; then, no drug is given until the prothrombin time is again down to 30 seconds or less, after which the drug is again given cautiously in doses of 100 mgs. (6) The Link-Shapiro technique, using undiluted whole plasma, or the Quick method is to be used for determining the prothrombin clotting time, and it is suggested that the Link-Shapiro method, using 12.5 per cent diluted plasma, be employed as an additional check or safeguard. All prothrombin times are given in terms of the Link-Shapiro (undiluted) method. (7) Unless contraindications arise, dicumarol therapy is to be continued in the chosen cases over a minimal period of 30 days, preferably 30 days after the last thrombo-embolic episode. (8) In instances of hemorrhagic manifestations, the use of synthetic vitamin K preparations in doses of 60 to 75 mgs. and transfusions of fresh whole blood (may be citrated) are recommended.

A comparison of the patients in the "control" group with those in the "treated" group showed a striking similarity in regard to age, history of previous infarction and estimated severity of

*Read before the Seventy-fourth Annual Session, Arkansas Medical Society, Fort Smith, April 17, 1950.

the current attack. Although the estimate of severity of the attack for each patient at the time of diagnosis is admittedly arbitarary, the results suggested that the treated group contained a somewhat greater proportion of severely ill patients. The control and treated groups were closely similar when the medical histories of cardiovascular disease and the locations of the original infarcts were compared.

Of the patients in the control group who did receive some anticoagulant therapy, often for short periods only, 3 out of 5 were given anticoagulants after the development of a thrombo-embolic complication. The remaining patients received them because of pressure on the part of the family or a private physician or for miscellaneous reasons.

In the computation of the rates presented in the following paragraphs, certain corrections were made to simplify the presentation and to make sure that no bias existed which might favor the treated group. In both groups all rates for thrombo-embolic complications and hemorrhagic manifestations, as stated in this interim report, refer to conditions diagnosed by laboratory, electrocardiographic and clinical methods.

Where as 23.4 per cent of the patients in the control group died, only 16 per cent of the patients in the treated group died. Thus, a third of the individuals who would have died without anticoagulant therapy survived the specific attack under consideration when anticoagulants were given. This difference is statistically significant. As previously anticipated, treatment with anticoagulants reduced the death rate largely by reducing the incidence of those thrombo-embolic complications which, directly or indirectly, result in death.

The death rates by week of illness were highest during the first two weeks, but were still considerable during the third and fourth week. For each period, the death rate for the control patients was found to be significantly greater than that for the treated group. These figures indicate that anticoagulant therapy, if not used before, should be begun even as late as the second or third week after a myocardial infarction has occurred—or later, if complications have developed; and, secondly, that, to give maximal protection, anticoagulant treatment should be continued for at least four weeks after the last thrombo-embolic episode.

The greatest benefits in the reduction of mortality are in patients 60 years of age or older. Hemorrhagic complications have been so few and so mild throughout the entire study, and the benefits of treatment of patients in the older age group have been so pronounced, that we do not hesitate to prescribe anticoagulants for older patients. It should be recognized, however, that older patients have a higher incidence of unrelated complications. While the crude death rates for patients less than 60 in both the treated and the control groups did not show a significant difference, the incidence of thrombo-embolic complications was high in these groups, and the incidence of thrombo-embolic complications was markedly lower in the treated group. Such thrombo-embolic complications may not only be serious incidents in themselves, but they may result in such serious permanent disabilities as hemiplegia (following cerebral emboli), chronic venous insufficiency (following thrombophlebitis) or residual myocardial damage (following repeated myocardial infarction).

The number of thrombo-embolic complications per 100 cases recognized clinically was 41.8 in the control group and only 13.1 in the treated group. In other words, the patients in the treated group experienced less than one-third as many thrombo-embolic complications as those in the control group did.

When the rates of thrombo-embolic complications by week of illness are considered, the advantage of using anticoagulants is clearly demonstrated for each of the first four weeks of illness. The incidence of thrombo-embolic complications, like that of deaths, is highest in the second week after coronary thrombosis or infarction, but is marked through the first four weeks. This, again, clearly indicates the importance of beginning anticoagulant therapy even as late as the second or third week after a myocardial infarction. Since it is impossible to predict from the condition of the patient during the first week whether thrombo-embolic complications will develop during subsequent weeks and whether death will occur from them, it is important to give anticoagulant therapy to all patients with coronary occlusion and myocardial infarction.

Locally, our practice has been to attempt to administer heparin intra-muscularly initially, and dicumarol orally to all patients in whom the diagnosis of coronary occlusion is suspected or established for a period of at least three weeks and for three weeks after any thrombo-embolic episode. Hemorrhagic complications have been minimal in our small series. Significantly, we have learned that dicumarol may be given in doses as small as 25 mgs. each day. Daily prothrombin determinations have, in our laboratories, been more dependable when performed, whenever possible, by the same technician, wherein the

personal factor of error is more constant. Economic considerations, which are inevitably encountered in private practice, have prevented the continuation of dicumarol therapy for the full three or four week interval. We have had no experience to date with long term ambulatory anticoagulant therapy.

Other indications for the use of anticoagulants are: (1) Thrombophlebitis or phlebothrombosis. (2) Pulmonary embolism. (3) Rheumatic heart disease with auricular fibrillation and multiple embolization secondary to intracardiac thrombi. (4) Congestive heart failure, regardless of cause, especially in the presence of a sustained arrhythmia. It is worthy of note that in the case of rheumatic heart disease with auricular fibrillation long term ambulatory therapy has been employed with some success by Nichol and Fassett, Foley and Wright. According to these investigators who have had patients on dicumarol continuously for as long as three and one-half years, no evidence of damage to the kidneys or to the liver has been demonstrated on the basis of laboratory tests and autopsy findings. The method, however, is fraught with difficulties in terms of patient's cooperation and economic factors. Prothrombin determinations should be done at least once or twice weekly. More recently interest has been stimulated in the possibility of reducing the risk of embolization following the administration of quinidine for the restoration to normal rhythm in patients with auricular fibrillation. Saland and his group have probably had more experience in this field than any other investigator. According to Wright, the question is at present open for further study and observation. According to Wright, anticoagulant therapy is contraindicated in the presence of: (1) Blood dyscrasias. (2) Serious liver disease. (3) Serious renal disease, especially with hematuria or calculi. (4) Gastro-intestinal ulceration or colitis. (5) Recent surgery or injury not sufficiently healed. (6) Unrecognized contraindications, such as unknown peptic ulcer or unknown diverticulitis.

Summary

1. The value of the anticoagulants, dicumarol and heparin, in the management of thrombophlebitis is considered to be conclusively established.

2. The importance of the use of anticoagulants as a postoperative measure in the prevention of thrombo-embolic complications has been definitely demonstrated.

3. Data based on extensive studies indicate that the death rate from coronary thrombosis with myocardial infarction can be reduced one-third, and the incidence of thrombo-embolic complications can be reduced one-half by intelligent use of the anticoagulants.

4. The value of anticoagulants in the prevention and treatment of thrombo-embolic complications of auricular fibrillation appears to have merit. The use of the anticoagulants on a long term basis in ambulatory patients deserves further careful study, as does the technique of the use of quinidine in conjunction with dicumarol in an attempt to restore auricular fibrillation to normal rhythm.

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BREAST CANCER, A BRIEF REVIEW OF THEORY AND THERAPEUTICS*

HENRY G. HOLLENBERG, M.D.
W. G. COOPER, JR., M.D., and
ROBERT D. JONES, M.D.
Little Rock

Cancer of the female breast is important to the surgeon because it is the commonest fatal malignant disease in women and because of important recent advances in our knowledge and treatment of it.

The new and astounding information about breast cancer in laboratory animals has come from work done on mice, rats and rabbits and, to a very limited degree, on monkeys. It is of fundamental interest but cannot, of course, be extra-polated to humans.

Breast cancer in laboratory animals develops exclusively (99%) in the female. In mice and rats, prolonged administration of physiologic doses of female sex hormones will produce breast cancer in most of the male mice so treated. Castration of female mice, by removing the female sex hormones, will prevent the development of breast cancer in "high cancer strains" which otherwise inevitably get mammary malignancy. These two experiments prove that the presence of female sex hormones is one of the causes of, and prerequisites for, the development of breast cancer in mice and rats.

By selective breeding over many generations, families of mice have been developed which are either "high cancer strains" or "cancer resistant strains." The females of the "high cancer strains" all develop fatal, metastasizing carcinoma of the breast shortly after puberty. The "cancer resistant strains" females never do. Cancer of the breast is therefore a hereditary disease in mice.

It has been found that the milk from "high cancer strain" mice has in it some substance which causes breast cancer. When "high cancer strain" baby mice are suckled by "cancer resistant" mothers, a few will develop breast cancer at maturity, but most escape it. Conversely, "cancer resistant" baby mice, when fed or injected with milk from "high cancer strain" mothers, develop breast cancers in a high percent of cases. The substance in the milk is a complex mucleo-protein which reproduces itself through many animal passages. It has numerous qualities of a virus. The infective nature of this type of breast cancer in mice seems proven.

The protein balance or general metabolic state of the mice is also a factor in their developing breast cancer. Well or adequately fed groups have a much higher incidence of mammary malignancy than do starved ones. Injection of potent carcinogens at a distance from the breasts will cause mammary cancer in susceptible mice.

It would seem that breast cancer in mice is either a multiplicity of diseases or one which development is influenced to varying degrees by heredity, sex hormones, a virus-like milk factor, nutrition, and overwhelming carcinogens.

None of this can be applied directly to man. There have been reported cancer families which in repeated generations developed breast cancers and many physicians believe the carcinoma disposition is an inherited trait. The new and powerful sex hormones influence the cells of cancer but no causative relationship is known. Caution in administration of them is indicated.

In contrast to the advances in theoretical knowledge the best cure for cancer of the breast is still early and radical surgical amputation. Breast cancer is the commonest malignancy in women. Haagensen says that 4% of all women (one out of 25) develop it. We can estimate that there are now 2,700 cases in Arkansas. If these women are operated on before axillary spread of the disease takes place, 75% will be cured. If they come to surgery late, we can still salvage 25%. It is this 25% with axillary involvement which are lost by inadequate surgery, simple mastectomies, and procrastination. X-ray has no place in pre-operative therapy, but seems logical as a post-operative adjunct.

To diagnose breast cancer, we must examine routinely all patients' breasts, whether the breast is a primary complaint or not. Yearly examinations will pick up early cases. Self-examination each month can also, if the attendant propaganda does not stir up too much cancerphobia. A thorough breast examination takes time, with gentle palpation of the breast when the patient is erect and lying down. The fingers and the flat of the hand are both used, and the axilla is carefully searched for hard nodes. An extra five minutes so invested by the LMD may initiate a five-year cure. The finding of a suspicious mass in the breast necessitates immediate action. If there be any doubt as to the diagnosis, we recommend biopsy in the operating room so that cure may be immediately undertaken. Delay is dangerous and its does seem as though an infected biopsy wound is of ominous omen. Once the diagnosis is proved in a curable case radical mastectomy should be carried out. This means a meticulous 3 to 4 hour job, which undertakes to remove the skin over the breast, giving the tumor a 3-fingerbreaths margin, and all the tis-

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sue from skin to chest wall and axillary down to the last lymph cell. This includes the subcutaneous tissue, fat, both pectoral muscles and the sheath of the axillary vein. Those wishing to read a master's word in these technical details are referred to Haagensen's article in Surgery, Vol. XIX, 100, 1946, entitled "A Technique for Radical Mastectomy."

We now have several methods of therapy available to patients with inoperable or terminal breast cancer. Pain from metastasis can be cured or relieved by local X-ray therapy to the involved area. Relatively small doses of X-ray delivered directly to the bony metastasis are the best known method of treatment. Local X-ray therapy is also of value in causing regression of other recurrences or metastasis. This should be tried first. X-ray or surgical sterilization of premenopause women may relieve the pain of bone involvement and should be used alone or in conjunction with direct radiation for this dire complication.

Since Huggin's brilliant results in therapy of prostatic cancer with Stilbestrol, many workers have shown that hormone therapy is of great value in the palliative therapy of breast cancer. Estrogenic hormones work best in women who are at least five years beyond the menopause and in the older age groups. In about 50% of these cases, it will cause regression of soft tissue involvement in skin or lymph nodes, lungs, or liver with consequent relief of painful masses and dyspnea. It generally takes two or three weeks of treatment for the improvement to start and may take five months. The dose recommended is at least 3 mgm./day p. o. or 5 mgm./1 m., 2 times a week. In addition to the specific effect of relieving pain and dissolving the cancer, the estrogens may cause great systemic improvement and a sense of well-being. The side effects are negligible except in premenopausal women, in whom this therapy is not to be used as it may cause acceleration of the disease.

Male sex hormones can be given without regard to menstrual status. They will also give relief of pain in 50% of the cases and cause regression of bone metastasis in 25% and of soft tissue disease in 15%. The dose is Testosterone 100 mgm., 1 m. 3 times a week for 10 weeks and then 60 mg. daily by mouth. Some few patients require more. Results may appear in a month or longer, but therapy should be continued for at least five months before failure is acknowledged; if the therapy helps, it should be stopped only on definite indications. Androgen may cause unpleasant side effects, such as masculinzation, but these are a trivial price to pay for the relief of pain. Before therapy is started the blood calcium level is determined. If this is high, or becomes high during therapy with Androgens, the drug must be stopped lest kidney failure occur.

FIVE-YEAR END RESULTS

This series consists of the cases of all female patients with cancer of the breast, both early and advanced, admitted to University Hospital Tumor Clinic, from, 1940-1945.

		5-Year Survivals	
TOTAL NUMBER OF PATIENTS ADMITTED	116	28	
Indeterminate Group	38		
Dead with 5 years of other causes without recurrence of cancer	32		
Lost track of within 5 years without recurrence of cancer	6		
Determinate Group	78	28	
Dead as a result of cancer	45		
Lost track of with cancer	5		
Living with persistent disease	5	5	
Living with recurrent cancer	3	3	
Free from cancer at 5 years or more	20	20	25.6%

Prepared by Central Cancer Registry, Arkansas Cancer Commission, Miss Virginia Woods, Statistician.

CARCINOMA OF THE FEMALE MAMMARY GLAND UNIVERSITY HOSPITAL TUMOR CLINIC, 1940-1945

Disposition of Cases

		5-Year Survivals
TOTAL NUMBER OF PATIENTS ADMITTED	116	28
I—Patients previously treated elsewhere	34	4
A—No further treatment	8	0
B—Further treatment by radiation	19	4
C—Further treatment by surgery	7	0
1—Palliative limited operation	0	0
2—Radical mastectomy	2	0
3—Simple mastectomy	5	0
II—Primary cases	82	24
A—Not treated by surgery or radiation	3	0
B—Treated by radiation only	5	0
C—Treated by surgery	36	6
D—Treated by surgery and radiation	38	18
1—Palliative limited operation	0	0
2—Radical mastectomy	61	20
3—Simple mastectomy	18	8

Prepared by Central Cancer Registry, Arkansas Cancer Commission, Miss Virginia Woods, Statistician.

These statistics, are presented to put on record the problem of indigent patients with cancer which this state is facing. The report for 1945-1950 will, through the help of the physicians in the state, and the American Cancer Society Field Army and the Arkansas State Cancer Commission, be more cheerful.

UROLOGIC PROBLEMS IN CHILDREN*

BARNEY P. BRIGGS, M.D.
and
JAMES W. HEADSTREAM, M.D.
Little Rock

Urologic conditions in children are very frequently overlooked and neglected. Often the pathology is minimal and slowly progressive, so, if arrested during its early stages, there will be complete recovery. Early diagnosis and correction cannot be over emphasized. The "Let the Child Alone, and He Will Probably Outgrow It," idea is certainly to be condemned. With a more urologic-minded attitude on the part of the family doctor and the pediatrician and with modern facilities available, the conservation of renal tissue by early correction should be more routine. When we all become as conscious of pyuria as we now are of hematuria the day will arrive when these unfortunate children are relieved of their condition and do not die an early renal death.

For practical purposes these urologic lesions in children are divided into obstructions and developmental defects.

Problems of urinary obstruction and infection are closely related. Obstruction causes urinary stasis and back pressure. Urinary stasis predisposes to infection and, once infection is established in the presence of obstruction, bacteriologic cure is seldom achieved without removal of the obstruction. Various combinations of obstruction and infection constitute over 90% of the important urologic problems in children. The character and extent of these destructive changes depend upon the location and nature of the obstruction and the presence or absence of complicating factors, notably infection.

Stenosis of the urethral meatus is the most common obstructive urologic condition in children. One of the more common symptoms produced by narrow meatus is bed-wetting. This involuntary urination, or enuresis, becomes a clinical entity when it occurs after the age of three years.

The obstruction causes congestion of the posterior urethra with a low threshold for the voiding reflex.

Meatotomy, urethral dilatations, and instillations of increasing strength of silver nitrate solution up to 1% will relieve many of these children. Any that are not relieved in from 4 to 6 weeks should have a cystoscopic examination of the lower urinary tract. (Case Report No. 1 demonstrates this.)

Of course, there are patients with enuresis in whom no obstruction can be demonstrated but often the change in the posterior urethra is the same as if a stricture or narrow meatus were present. In some of these cases in which no pathology can be demonstrated there is a response to ephedrine sulfate, grains 3/8, at bed time. Interference with sound sleep allowing stimulation of the suprasegmental reflex when the bladder is filled will permit a normal voiding reflex. Once the habit is broken for a month or longer there is recovery from the symptom. Psychological correction is necessary at times.

The so-called "Pyelitis of Childhood," is of very frequent occurrence. This acute urinary infection occurs chiefly in girls and in most cases is due to contamination from the rectum caused by improper cleansing after bowel movement. A great service can be rendered to these little girls by instructing their mothers in the proper way to clean them.

When a urinary infection is encountered in a boy, an anomaly or other organic lesion in the urinary tract is usually found.

A combination of a narrow urethral meatus and a vaginitis contributes to frequent recurrence of urinary infection. Of course, at times the infection may be due to upper urinary tract pathology which must be ruled out with pyelography. This can most often be done with intravenous urography, and indefinite findings further studied with cystoscopy and retrograde pyelography. It is felt that a child with two attacks of urinary tract infection should have a complete urological study.

A female with pus in the urine should have a urine analysis of a catheterized specimen, for very often the pus is from vaginal contamination. Also, vaginal contamination of urine will frequently be found the cause of unexplained traces of albuminuria.

When no disease is found in the upper tract, examination of the vagina and urethra with adequate local treatment, along with the proper stool hygiene, will, in most cases, stop the recurrence of pyelonephritis.

Recurrent attacks of urinary infection are definitely capable of causing permanent damage. Chronic pyelonephritis may produce nephrosclerosis and hypertension in later life. (Case No. 2.)

A complete urological examination is the most scientific manner of approach to the management of urinary tract infections, but it is not

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always feasible to subject the patient to this procedure, and in many instances it is not necessary.

For the practical medical management the physician should have a presumptive idea of the type of infecting organism. A Gram's stain of the urinary sediment, which is readily available to all, will provide information of whether we are dealing with a bacillary or coccal type of infection.

Approximately 85% of urinary infections are due to gram negative organisms and about 90% of these infections will respond to the sulfonamides. For this reason the logical choice of drug for use in the initial treatment are the sulfonamides. They can be taken orally at home and are available at the lowest cost. The triple sulfonamides are well tolerated and are so soluble that adjunctive alkali therapy is not indicated. Not more than 2 grams a day is usually all that is necessary as the larger percent of sulfonamides are eliminated in the urinary tract affording a good concentration of drug.

The next drug of choice from a practical viewpoint is mandelic acid as it has a wide range of efficiency. The most abused antibiotic in the treatment of urinary infections is penicillin, since this is indicated only in the coccal infections and these are in the 15% minority.

A failure in response to the more common, readily available, and easily administered drugs should demand a complete urinary tract study with further selection of drugs in accordance to the findings and following identification of the offending organism by culture. Most of the failures in children are due to ureteropelvic and vesical neck obstruction, and no amount of urinary antiseptic, of whatever choice, will cure these cases. The development of the newer drugs and antibiotics has afforded excellent control of a large number of organisms but Pseudomonas Aeruginosa remains the most resistant and we have no specific therapeutic agent at this time.

Vesical neck obstruction is encountered more often in boys than in girls. Early recognition is very important as irreparable renal destruction occurs in neglected cases.

History is very important in the diagnosis of vesical neck obstructions. A history of frequency, dribbling, and straining with urination is very suggestive of bladder neck obstruction and should demand investigation. Determination of residual urine by passage of a small catheter should be the next step. The physician should not expect a resistance to catheterization in all cases since, in some cases of posterior urethral valves, the retrograde passage of a catheter is not hindered but the flow of urine is interfered with.

In early cases of obstruction in the lower tract compensatory hypertrophy of the bladder wall enables the viscus to empty itself satisfactorily despite the obstruction. The time arrives when the obstructive resistance is greater than the vesical expulsive force. The bladder can no longer empty itself, gradually decompensates, and becomes dilated. The condition is analogous to that of cardiac decompensation. When the intracystic pressure equals and periodically exceeds that of the peristaltic ureteral force the intracystic pressure is directly transmitted up the ureters and they in turn dilate and thicken in a compensatory effort, and later decompensate with resulting bilateral hydronephrosis. As the process progresses there is langour, anorexia, anemia, vomiting, loss of weight, urosepsis, and uremic coma. Complete urologic investigation, proper preoperative preparation, and transurethral resection of the vesical neck will afford relief for these cases and prevent irreparable damage if the child is seen before this has already occurred. (Case No. 3.)

Obstruction at the ureteropelvic juncture is another frequently neglected lesion. The nearer the obstruction approaches the ureteropelvic junction the more acute and earlier in appearance are the symptoms of hydronephrosis, and, other things being equal, the more rapidly destructive the process.

The obstructive lesion in infants and children causing readily palpable hydronephrosis is usually at or near the ureteropelvic juncture. The more common symptoms that point to ureteropelvic obstruction are recurrent pyelitis and dull aching pain in the flank. Urologic investigation will demonstrate the hydronephrosis and ureteropelvic obstruction which should be corrected by the proper pyeloplasty. (Cases No. 4 and 5.)

Developmental defects range from mild hypospadias to undescended testicles, to complete exstrophy of the bladder. Proper surgical treatment should not be delayed.

The optimal time for correction of bladder exstrophy by ureterointestinal anastamosis and cystectomy is around from 3 to 4 years of age, or whenever definite bowel habits are formed. (Cases No. 6 and 7.) The plastic correction of the genital abnormality is performed later.

Cryptorchidism should be corrected prior to puberty. A few weeks of gonadotropic hormone at age from 10 to 12 is indicated. Failure in descent is sufficient evidence that the testicle will not descend to its normal location at puberty. Orchidopexy, properly performed, and repair

of the usually accompanying hernia will preserve the function of the testicle.

CASE REPORTS

Case No. 1. E. G., male, age 4 years. History of enuresis. Urine negative. Failed to respond to usual treatment. Intravenous urography revealed no abnormalities. Hypertrophy of the verumontanum noted on cystourethroscopic examination. Resected transurethrally with the McCarthy Infant Resectoscope with complete relief of symptoms.

Case No. 2. R. O., male, age 10 years. Long history of recurrent urinary infection. Six months prior to admission had noted vertigo, visual disturbances, headaches. Urine: XX albumin, 20-30 wbc, 10 rbc, specific gravity 1.010. Blood pressure 180/110. Excretory pyelogram showed nonfunctioning left kidney. Retrograde pyelogram showed compensatory hypertrophied right kidney with negative urine. Left kidney was atrophic with 15-20 wbc. Left nephrectomy and pathology examination noted left ureteropelvic obstruction, pelvic dilatation, scarred atrophic parenchyma. Microscopic examination revealed a very few functioning units with diagnosis of Chronic Pyelonephritis. Gradual disappearance of symptoms of hypertension and six months later blood pressure was 110/78, with negative urine.

Case No. 3. Male, age 19 years. Long history of urinary difficulty and repeated episodes of chills and fever. Examination: Markedly distended bladder. Residual urine 2,000 cc. Anemia. N.P.N. 110 Mgm %. Cystoscopy and Cystogram: Contraction of bladder neck, multiple diverticula, bilateral hydroureter and hydronephrosis. Treatment: Indwelling ureteral catheter for 3 months on ambulatory basis. N.P.N. dropped to 50 Mgm %. Transurethral resection of bladder neck. Result: Able to empty bladder completely but no change in upper urinary tract dilatation. Infection still present, but improved.

Case No. 4. S. S., female, age 4 years. Recurrent urinary tract infection over a period of 18 months. Marked frequency, urgency and nocturnal enuresis. Urine: Trace of albumin and many pus cells. Cystoscopy: Normal left kidney with no infection; mild, right hydronephrosis. Culture: Colon B. Operation: Pyeloplasty. Findings at operation: Ureteropelvic stricture and aberrant vessel. Result: Relief of symptoms.

Case No. 5. W. S., female, age 6 years. Recurrent urinary tract infection with repeated attacks of chills and fever. Treated for everything but urinary infection for one year, until pediatrician was consulted. Urine: X albumin and many pus cells. Cystoscopy: Normal left kidney with negative urine. Right kidney mildly hydronephrotic and culture of urine revealed Aerobacter Aerogenes and Colon Bacillus. Operation: Ureteropelvic stricture; pelvioplasty. Result: Excellent. Relief of symptoms.

Case No. 6. Male, age 5 years. Exstrophy of the bladder. Ureterointestinal anastamosis (Jewett Technique), in two stages with removal of bladder. Result: Excellent on three-year follow-up. Genital correction to be done later.

Case No. 7. Female, age 15 years. Exstrophy of the bladder. Ureterointestinal anastamosis (Flock's Technique) and removal of bladder at second operation. Two-year follow-up with good result. Genital correction elsewhere.

Summary

Proper early attention to urologic problems in children will conserve renal tissue.

A child with repeated attacks of urinary tract infection should have a complete urological study.

Neglect on the part of the family physician, pediatrician, and sometimes on the part of the urologist, will permit minor lesions to become major ones and result in irreparable damage.

A "Pyuria Conscious Attitude" will protect the kidneys of these patients. In other words, "Repair It in Childhood, or Remove It in Adulthood."

THE 1951 ANNUAL SESSION

Over five hundred physicians registered for the Seventy-fifth Annual Session of the Society held at the Hotel Marion, Little Rock, April 23rd-25th. The scientific program was of unusual interest and members praised the speakers and addresses as one of the best programs in many years. The change in meeting place from the auditorium seemed to have popular appeal. The House of Delegates voted an increase in the annual membership assessment to $25 per year effective January 1st, 1952; provided for a registration fee at the annual sessions of five dollars from each member in active practice, disapproved of a constitutional amendment which would have made membership in the American Medical Association a requirement for the membership in the Arkansas Medical Society and indorsed a resolution calling for discontinuance of payments for postgraduate instruction by Federal tax funds. The Society will next meet in Little Rock. Officers elected are: Chas. R. Henry, Little Rock, President; S. A. Drennen, Stuttgart, President-Elect; Frank Kumpuris, Little Rock, First Vice-president; John H. Wilson, Magnolia, Second Vice-president; D. W. Goldstein, Fort Smith, Third Vice-president; Councilor, First District, L. H. McDaniel, Tyronza; Third District, J. O. Rush, Forrest City; Fifth District, D. E. White, El Dorado; Sixth District, C. A. Archer, De Queen; Seventh District, E. Driver Rowland, Hot Springs National Park; Ninth District, Fount Richardson, Fayetteville; Tenth District, J. M. Kolb, Clarksville. An amendment to the By-Laws adopted provided for the election of Vice-councilors from each congressional district and these are: First District, W. E. Berry, Jonesboro; Second District, Hugh Edwards, Searcy; Third District, J. M. Roy, Forrest City; Fourth District, H. W. Thomas, Dermott; Fifth District, George C. Burton, El Dorado; Sixth District, E. V. Dildy, Jr., Nashville; Seventh District, H. King Wade, Jr., Hot Springs National Park; Eighth District, Ed Gray, Little Rock; Ninth District, Lee A. Dean, Rogers, and Tenth District, Roy A. Millard, Russellville. R. B. Robins was elected delegate to the American Medical Association and Earle H. Hunt was elected alternate.

CASE REPORT FROM THE UNIVERSITY OF ARKANSAS SCHOOL OF MEDICINE AND UNIVERSITY HOSPITAL CLINICAL PATHOLOGIC CONFERENCE

ANDERSON NETTLESHIP, M.D., Editor

Case Presentation

B. B. WELLS, M.D.

The patient was admitted September 29th at 2 a. m. in coma and remained in coma until September 30th at 4 p. m. She was started on sodium chloride and KNL solution. Her blood sugar on admission was 634 mgm%; CO_2 combining power 10 vols.%; urine sugar 4 + and positive for acetone. She was given 50 u. regular SC and 50 regular I. V. She also received two hours later 80 regular in infusion. She was given 800 cc. 5% glucose in sodium chloride at 4 p. m. Her blood sugar continued to drop and by 8 a. m. of September 30th was 93mgms%. She was given 30 u. of insulin at 9 p. m., September 29; 50 u. at 11 p. m.; 50 u. in infusion at 2 a. m., September 30 and 25 u. at 8 a. m. of the same day. This kind of treatment was continued throughout her brief stay in the hospital. The patient's blood sugar ranged from 93 mgm% through 514 mgm% and the urine sugar ranged from 4 + to negative. When the patient was awake she was given 100 cc. 1/6 M lactate and Kepler diet. The last blood sugar taken on her before she expired early in the morning of October 3rd was 235 mgm%. At that time her urine sugar was 1 + and urine acetone: trace.

We have in this case no diagnostic problem. It is evident that we are dealing with a patient who died in prolonged diabetic coma and who must be listed as a therapeutic failure. As you know individuals who acquire their diabetes late in life usually have a good prognosis. In this 58 year old patient we may be justified in assuming that the diabetes was relatively mild. The history on this patient is not clear, she had been on insulin, how much we are unable to determine. We are told that she received 80 u globin insulin a day and on another occasion we were told she received 20 u globin insulin a day. I question the veracity of such unreliable information.

When admitted to hospital this patient had been in coma for 24 hours. We all know that we are at great disadvantage if the patient has been in coma for as much as 12 hours. In receiving her record we also found the statement that the patient had not received any insulin for over three months. This lends support to the fact that she was not a severe diabetic but must have some infection or other condition which precipitated her coma.

Summary of Clinical History and Progress

The patient is a 52-year-old white female with one previous admission, in 1946, at which time she received treatment for menstrual irregularity, abdominal pain and tenderness, and diabetes mellitus. Diabetes was apparently controlled with diet, 180 grams CHO, protein 80 grams, fat 45 grams, and 25 u globin insulin daily. She was followed irregularly in diabetic clinic and exhibited a constant glycosuria in spite of receiving 80 units globin twice daily. Her last clinic visit was 6-24-47.

On 29 September 1950, the patient was brought to the emergency room by friends who stated that they had been unable to arouse her since the day before. She was thought to have had virus "flu" and they knew she had taken no insulin since 28 September 1950. She was referred to the University Hospital after being seen by a local medical doctor.

Examination at time of admission revealed a comatose, obese, white female who was acutely ill. Her blood pressure was 75/55; pulse 100; respiration 30 (Kussmaul type); temperature 99°.

Skin: Dehydrated.

Head: Fruity odor to breath, eyeballs soft, mucous membranes dry.

Chest: Heart: Negative. Lungs: Clear.

Abdomen: Obese, no organs palpable.

Pelvic: Marked vulvitis. Complete examination deferred.

Extremities: No significant abnormalities.

Reflexes: Active and equal.

Course in Hospital and Laboratory Data

Summary of treatment is given below in addition she received:

50,000 u penicillin every 3 hours.

Streptomycin 0.5 gm. bid.

Alcohol sponge as needed for temperature.

It is clear that this is a classical case of diabetes: typical dehydration, fruity breath, rapid pulse, vulvitis.

Our treatment of the patient deserves quite a bit of comment. We treated the adicosis, dehydration and sodium chloride loss. We felt the latter was corrected fairly well.

There may be some question about the amount of insulin. Ordinarily we would start with a dosage of twice this amount. It depends upon the clinical history. The KNL solution was to combat the acidosis. Correcting the acidosis is more important than treating the coma, even than treating the high blood sugar which may be more than 500 mgm%. The patient did not

respond as well as we would have liked because coma was not corrected within 6 to 8 hours. The patient remained in coma too long. The patient continued to have a positive acetone in the urine so we were not able to control the acidosis. The patient died suddenly while drinking some orange juice. This particular incident we find quite frequently in this disease, sudden death while sitting up drinking.

We are left with the problem of why this patient died suddenly? Why the sudden death? There are a number of possibilities to be considered: (1) a patient in coma over a long period of time is very likely subject to infection—pulmonary or otherwise. A pulmonary infection is common: (2) The temperature of this patient went up to 103° which may be indicative of infectious processes; (3) arteriosclerotic complications could have caused the patient's death; (4) also cerebro-vascular accident is a good possibility, however, neurological signs were atypical; (5) there is also a possibility that the patient died of a myocardial infarction, as might be suggested by the suddenness of death; (6) the patient might have been subject to degenerative processes due to toxemia, anoxemia, hyperglycemia. Patients in diabetic coma more than 12 hours usually die.

Physician: Was a blood amylase test run?

Medical Resident: No.

Dr. Wells: There is nothing else contributory. A larger amount of insulin may have been required in this case. However, if too much insulin is given too rapidly the resulting rapid fall in blood sugar may result in insulin shock. It has been shown by White and others that insulin shock is related to the rapidity of blood sugar fall.

We may say that this patient died as a result of her diabetes mellitus and probably also due to an intercurrent infection. She had a severe vulvitis and may have had terminal pneumonia.

Final Clinical Diagnosis

Diabetes Mellitus.

Vulvitis and probably terminal pneumonia.

Pathologic Diagnosis

Diabetes Mellitus, with amyloidosis of islets of Langerhans. Chronic pancreatitis.

Kimmelstiel-Wilson kidney lesion.

Acute necrotising pancreatitis.

Chronic cholecystitis and lithiasis.

Vulvitis.

Generalized arteriosclerosis.

Atelectasis of right lung.

Mild cardiac hypertrophy.

Obesity.

Pathologist: We found the patient to be an obese white female who appeared older than the stated age. The gross findings of significance were: obesity, generalized arteriosclerosis, fat necrosis about the pancreas, heavy fatty infiltration of the pancreas, mild fatty infiltration of the liver, granularity of kidney cortex and vulvitis. There was thickening of the gall bladder wall and gall stones in the gall bladder. The common duct was dilated and the common duct and pancreatic duct had a common opening at the ampulla.

Microscopic: We were impressed with the amount of chronic pancreatitis and fibrosis which the pancreas showed. The islets were hyalinized (amyloid). We should like to contrast these islets with those from the pancreas of another patient. (Section demonstrated from the pancreas of a three-year-old white female who died from diabetes mellitus.) In this pancreas the islets, in contrast to those of the older patient, showed marked hydroptic degeneration. It is now considered that such degeneration is actually excessive cellular glycogen. (1)

We believed this patient died from her diabetes mellitus plus an attack of acute necrotizing pancreatitis. We think she had many attacks of chronic pancreatitis over a period of many years as a result of gall stones being passed down into the common duct area opening. Death in a diabetic is always a problem. We also have often been impressed by its acute nature, the same is true of acute pancreatitis.

Dr. Wm. A. Riley: I should like to make note of the difference in childhood diabetes and the disease as it occurs in older persons. We are familiar with this last case as shown here and were impressed by the rapidity of its onset.

REFERENCE

1. Toreson, W. E.: Glycogen Infiltration (so-called Hydroptic Degeneration) in the Pancreas in Human and Experimental Diabetes Mellitus. Am. Jr. Path. 27, 327, 1951.

The Third Western Institute on Epilepsy will be held in Salt Lake City, Utah, the weekend of June 15 to 17, 1951. This meeting will be of wide interest to physicians, social workers, public health nurses, employers, teachers, rehabilitation workers, state hospital personnel, educational leaders, etc. A small registration fee will be required.

Further information may be obtained by writing to Dr. Harriot Hunter, University of Colorado Medical Center, 4200 East 9th Avenue, Denver, Colorado or Dr. Jean P. Davis, University of Utah, College of Medicine, Salt Lake City, Utah.

DIAGNOSIS OF TUMORS OF THE LARYNX*

JAMES B. COSTEN, M.D.
St. Louis

From the Department of Otolaryngology, Washington University School of Medicine and the Oscar Johnson Institute.

The primary symptom of tumor of the larynx, benign or malignant, is hoarseness. It is likely to be minimized or disregarded by the patient who constantly uses his voice. Persistent hoarseness in the absence of nasal infection should be as familiar in the minds of people, as abdominal pain with nausea, the clue of appendicitis. Until the larynx is visualized, no one can say whether the patient has any one of the various paralyses of the vocal cord, a benign or milignant tumor. Until a biopsy is obtained, the diagnosis of benign or malignant tumor cannot absolutely be established. The second important symptom is dyspnoea, either from obstruction to the airway by growth of the tumor, or by wasting of air during speech, with cords held open by the mass. Tickling sensations in the throat and cough are common symptoms, and are due to abnormal pressure of the tumor. Along with coughing spells, hemoptysis occasionally occurs. Pain in the throat may be due to ulceration. Pain is a common symptom of tuberculous laryngitis, and is much more uncommon in tumors, benign or malignant. Contact ulcer is the simplest lesion, resulting from vocal abuse, and recedes only on proper voice rest.

The etiology of tumors of the larynx can be very briefly stated. Of benign tumors, abuse: which amounts to overuse plus external agents, as drying from smoking and dry atmosphere, inflammation and injury. As to the etiology or etiologic factors of cancer of the larynx, these are as vague as the background of cancer anywhere else in the body. Age has no bearing on the etiology of benign tumors, because as we will demonstrate in the illustrations, the same benign tumor occurs at 6 or 60. Sex is no factor in the benign tumor, and senile changes in epithelium do not appear important. Heredity plays no part in benign tumors, on the other hand, all the factors have some bearing when tumor is malignant, entire families showing malignancy of some body tissue—obviously an hereditary lack of resistance to cancer growth. Malignant tumors of the larynx are commonest in the sixth decade of life, and in percentages of various large series, 90 to 95% occur in males, making it almost universally a disease of the male sex.

The diagnosis of tumor begins with the mirror image, and absolutely every part of the larynx must be visualized; someone aptly, once said, "Death may lie under a folded epiglottis." Sometimes indirect examination is entirely impossible in an adult and almost always impossible in children, in which case, a direct examination must be made. A thorough-going history and X-ray of the chest may reveal tuberculosis in a lesion which is borderline between a very slight tumefaction of the false cord and atypical surface changes. History and serological studies may prove the lesion to be syphilis, when cellular changes in the biopsy might otherwise convince the operator that his biopsy was inadequate or incomplete. X-ray study of several planes, using the recently perfected technique of laminograms, may throw a very important light on the location and character of a tumor involving one side of the larynx.

Papilloma, commonest of all benign tumors of the larynx, occurs usually in children below puberty. It may occur at any age of life. Growth is usually exuberant, the histological structure is a vascular core of fibrous tissue, running in a standard pattern, with a papillary outline. Only rarely does it undergo milignant degeneration, but usually recurs after being peeled off. These masses of papilloma may be such extensive growths as to fill the larynx and embarrass respiration, tracheotomy sometimes being necessary before attempted removal. Laryngeal polypus is the next common lesion and when sufficiently irritated, and of long enough standing to become fibrous, is termed fibroma of the cord. Hemangiomata, except when cavernous in children with lesions which are extensive about the pharynx and larynx, are simple affairs, ranging from organized clots to very fine, pedunculated, elongated, hairlike tumors lying on the surface of the cord. Examples of the latter are seen in music teachers, whose use of the voice, although proper, is continued and strenuous, producing high notes. The singer's node, or fibroma, occurs at the junction of the anterior and middle thirds of the cords, almost always bilateral, exactly opposite. This seems to be point of stress in production of sound, and measures exactly half way from the tip of the vocal process to the anterior commissure of the larynx. The smaller of these will sometimes disappear when better vocal hab-

*Read before the Seventy-Fourth Annual Session of the Arkansas State Medical Society, Fort Smith, Arkansas, April 18, 1950.

its are instituted, and the largest need removal by peeling, done with the greatest care, in order to retain the voice function. Prolapse of the ventricle is a term applied to a large, bulging, cyst-like mass which protrudes from the ventricle, and histological studies show these to be some kind of sacculation of the laryngeal mucosa, not strictly the wall of the laryngeal ventricle. Keratosis is an important benign lesion of the larynx, because it has the deadly suspicious appearance of malignant lesions, responds readily to removal and clearly not malignant when seen in histologic section. It's diagnosis, more than any other benign growth, warrants long observation for recurrence. Leukoplakia occurs as a benign lesion of the cords, as in other areas about the buccal and pharyngeal mucosa.

Now, diagnosis of malignant tumor of the larynx depends entirely upon the biopsy and histological studies, and location and extent of the lesion determines the type of treatment. If the lesion is small, limited to the middle or anterior third of one cord or even the anterior commissure, and low grade in classification, removal of one cord or laryngofissure or the anterior third of both cords may be the treatment of choice. However, if the lesion is in the posterior third, with or without fixation of the adjacent arytenoid, or occurs in any part of the false cord, or is subglottic, the best practice is total laryngectomy. The main condition influencing the extent of radical removal of the tissues, is the question of intrinsic or extrinsic lesion. If the lesion is found between the upper surface of the false cord, and the subglottic region only, may be said to be intrinsic, but requiring total laryngectomy; when extending upward above the false cord into the ary-epiglottic folds, and epiglottis or has metastasized to a cervical gland, this may be said to be extrinsic in type, and demands laryngectomy with block neck dissection on the side of extension.

Summarizing briefly, the major factor in the etiology of benign tumor is abuse of the larynx, whether handicapped by alcohol or tobacco; the largest group is vocational, such as teachers, speakers or singers, workers who must talk in noisy places, or people who live with deaf relatives. Absolute diagnosis depends upon one or more biopsies and histologic studies must be made. Hoarseness is the cardinal sign, and must be evangelized to the public with urgent emphasis. The patient must realize that the background of any recurring laryngeal tumor may be malignant growth, and cooperation, for his own sake, is vital. All benign lesions, especially keratosis, must be observed for a long period, and biopsy must be repeated on any and every recurrence.

The sections and sketches herewith, were selected to present a graphic picture of age variations, types of laryngeal tumors, and typical locations within the larynx.

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EDITORIAL

THE ATOMIC BOND

JOSEPH O. BOYDSTONE, M.D.
Colonel, Medical Corps, U. S. A. (Res.)
Hot Springs National Park

The atomic bomb has added a new terror and devastating force to the arsenal of war, and has increased many fold the number of potential casualties which the Medical World will be called upon to handle in the event this weapon of destruction is utilized against the civilian population of this country. National security makes it imperative that each individual of the Medical Profession understands the salient fundamental facts regarding the medical effects of an atomic explosion. It is essential, therefore, that pertinent medical information on this problem be disseminated to those people who will be charged with the responsibility of caring for the sick and wounded resulting from all types of atomic weapons.

The atomic bomb is primarily a strategic weapon and the choice of target and employment require evaluation the points to be used by this weapon which at one time caused the consideration of a great number of factors.

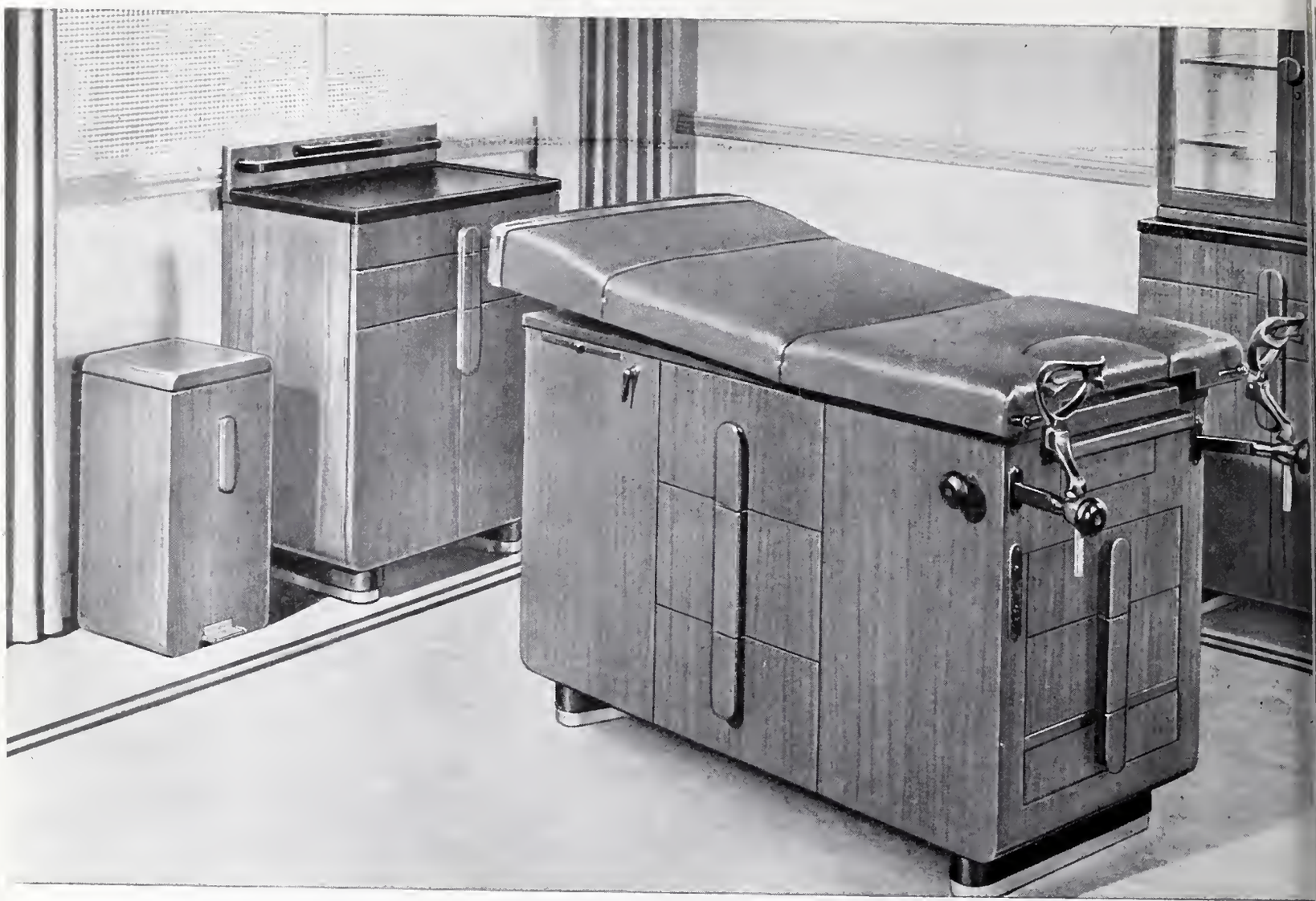
The first bomb was set off under experimental conditions from a tower at Trinity Site, Alamogorado, New Mexico, on 16th July, 1945. Since that time a great number of bombs have been utilized both from a destructive measure against an enemy and for experimentation.

In the two Japanese cities of Nagasaki and Hiroshima over 100,000 were killed, and as many were injured. If a bomb was dropped in such a way as to leave the area contaminated with radioactive material, other casualties might result and rescue and repair work would be hampered for a period of time. The area of damage, the number and kind of casualties and the extent of contamination would depend on how powerful the bomb was, and on how it was used —whether at high or low altitude on a clear or stormy day, or exploded in an adjacent river or lake.

The way in which a bomb is utilized would have its own particular type of hazard. In this discussion I am primarily interpreting data derived from the Japanese bombings in which an atomic bomb, considered as roughly equivalent to setting off 20,000 tons of TNT, was exploded at a height of about 2,000 feet above the earth on a clear day. At this altitude an atomic bomb of the power used at the two Japanese cities is estimated to have its greatest effect.

The Hiroshima and Nagasaki bombs caused total destruction and serious damage to buildings —death and injury to people—for 2 miles from the zero center or the point from which the bomb was set off; the extreme limit of damage was approximately 4 miles. The more powerful bombs or improved bombs which we have today could cause a wider area of damage.

The high air burst, such as that in Japan, leaves no dangerous amounts of radioactivity on the ground. Yet a bomb exploded in the air at a low altitude as in the Trinity test will pulverize and vaporize materials in its immediate vicinity. It will not affect as wide an area, and the screening effects of hills will be increased since the explosion takes place closer to the earth. Radioactive contamination will, however, be severe within a limited area if a ground burst.



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RANDOM THOUGHTS OF THE SECRETARY

February 25th. Visiting in Kansas City today and tonight riding the Southern Belle listening to the Big Show and Booneville's share of fame and then reading of Councilor-Sportsman Drennen in his sponsorship of gar fishing as related in TRUE magazine.

February 26th. Serving as lantern slide operator for Goldstein who is in rare form tonight speaking to the dentists of oral mucosa lesion, a talk which is received with much interest and intelligent questioning.

March 24. Driving 300 miles across Oklahoma to the Wichita Mountains near Fort Sill where a magnificent natural amphitheater, ringed with mountains, and a stage setting well designed affords an inspiring scene this moonlighted Sunday morning for portrayal of the Easter story by 2,000 costumed players to a reverent and attentive audience of over 100,000.

March 25th. With far less confusion and delay than attends departure from a University football game over 15,000 automobiles leave the mountains and head for localities far and wide, most of us pondering why Easter bells of joy over the resurrection should have the background of gunfire and grief and uncertainty for the many peoples of this world.

March 28th. With Goldstein and Kramer to Booneville where a goodly number arrive for the diagnostic clinic, Kramer providing the world's largest hamburgers for lunch en route and homeward to complete the duties of the day and in the evening night-clubbing in a genteel manner with Charlotte and Sid Wrightsman.

March 29th. With Monfort, Butt, Dickinson, Hunt, Richardson (a gate crasher) and Wrightsman to discuss changes in the Society's Constitution and By-Laws at length, a discussion which must inevitably lead into the AMA membership assessment and allied problems.

April 11th. Possibly now is the time to use the word "asinine."

April 20th. With Goldstein to Paris, having the good luck for the tire to flatten at the corner of North Elm and Mary, a location unknown to Jim Smith of Paris, conducting the cancer clinic and homeward uneventfully to finish our chores.

April 22nd. Pausing to park the car in Paul McConnell's garage as he starts on a fishing trip, we continue by rail to the convention city and greet the many in attendance at the GP meeting whose banquet tonight is a super production.

April 23rd. In and about the meeting throughout the day for the pleasures of meeting and talk with friends with the thrilling moment of Bob Robins' presentation from the group, a token of appreciation for untiring effort and total disregard of personal interest in the cause of medicine and freedom. Aboard the Rock Island for a few hours of wanted sleep and into Booneville in the early morning in order to care for local problems not otherwise to be disposed of in our absence.

April 24th. Tonight the gala social party to climax a scientific program which we believe has had more praise than one in many a day—a good day for the Society.

April 25th. The affairs of the annual session come to a close as Henry gives a program which well deserves full and earnest support by each member and so homeward with rain as a hindrance Ola east.

BOOK REVIEW

Physical Diagnosis: By Ralph H. Major, M. D., Professor of Medicine in the University of Kansas. New, 4th Edition. 446 pages with 469 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price $6.50.

This well known text, now presented in its Fourth Edition, has been revised and enlarged to include many recent advances in the interpretation of symptoms and signs in physical diagnosis. It is clearly written and concisely presented with many new illustrations which add greatly to its value as a textbook and reference volume. Each chapter has many items of historical data which are not only interesting reading, but also emphasize that the basic fundamentals of physical diagnosis in many instances have not changed greatly through the years.

The author has intentionally avoided presenting material on laboratory and X-ray diagnosis, concentrating his efforts on the importance of inspection, palpation, percussion, and auscultation in diagnosis, and the interpretation of the findings with these methods. While this volume is intended primarily as a textbook for students, it is a very valuable reference book for the practicing physician, and is recommended to all students and practitioners, alike.

Techniques in British Surgery: Edited by Rodney Maingot, FRCS. Illustrated. 734 pages with 473 figures. Philadelphia and London: W. B. Saunders Company, 1950. $15.00.

Twenty-nine British surgeons have written special articles for this text, emphasizing their technics.

Progress Volume—to accompany Hyman's Integrated Practice of Medicine. An appraisal of latest developments in therapeutics prepared by Harold Thomas Hyman, M. D., to accompany his four-volume Integrated Practice of Medicine. Contains cross reference to the original four volumes and an index system to all five volumes. 734 pages. Philadelphia and London: W. B. Saunders Company, 1950. Price $10.00.

It is the intent of this volume to bring up to date the previous four reference volumes set by this author. Newer contributions in medicine are summarized in alphabetical manner. The text is integrated with the original work by page references.

Current Therapy 1950—Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M. D. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 736 pages. Philadelphia and London: W. B. Saunders Company, 1950. Price $10.00.

This edition appears in excellent technical form contributing to ease of reading and use. It will prove a most valuable help to the physician who wishes to find a proper treatment for a given disease. It is certain to become more popular with each succeeding edition.

Regional Orthopedic Surgery: By Paul C. Colonna, M. D., Professor of Orthopedic Surgery, University of Pennsylvania Medical School. 706 pages with 474 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $11.50.

In this book the author has arranged, by body regions, the anatomy, pathology, fractures, diseases and treatment of the common clinical conditions. It would seem especially suitable for the general practitioner.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

DIAGNOSIS OF PULMONARY LESIONS DISCOVERED BY MASS ROENTGENOGRAPHIC SURVEY

Part I

Dumont Clark, M. D., Carl W. Tempel, M. D., and Kenneth D. A. Allen, M. D., The Journal of the American Medical Association, July 15, 1950.

The technic of mass roentgenography of the chest uses a small film that is not diagnostic, but indicates abnormalities which must be identified by further studies including a 14" x 17" roentgenogram.

The identification of a pulmonary lesion is no different from that of a diseased condition elsewhere. The history is of the greatest importance, especially that part dealing with contact with tuberculosis, the regions of the country in which the patient has resided, his occupations, age, sex, race and family history.

It is to be understood that the radiograph should be of good detail, optimum contrast and proper density. Evidence of early disease can be obliterated from the roentgenogram of an infected case, or can be simulated in a normal chest, by poor films. Interpretation of the radiograph is the important item.

Use of a fluoroscope is not only completely inadequate for the detection of early disease but can be a menace by producing a false sense of security.

The physical examination of the chest and the lungs is disappointing in most chronic pulmonary diseases, especially in the discovery of an early lesion. However, an evaluation of the circulatory status of the patient by physical examination may be of value. Enlarged external lymph nodes, by their location, number and consistency, may indicate carcinoma, sarcoidosis, tuberculosis, a blood dyscrasia or lymphoma. A biopsy of the node may then settle the diagnosis.

The differential diagnostic value of the temperature, pulse, and respiratory rates is not great. A rise in temperature may indicate an infectious process. Changes in the pulse and respiratory rates, in the blood cell count, the sedimentation rate, and urinalysis are common phenomena whose significance is well known.

Specific Diagnostic Procedures

Three different skin tests are commonly used, the tuberculin, the coccidioidin and the histoplasmin. If properly performed, these tests are reliable for the disease in question. With few exceptions, a repeated negative reaction rules out the disease in question.

If the patient with a pulmonary lesion has sputum, a twenty-four hour specimen should always be examined for tubercle bacilli. Without sputum, it will be necessary to culture the fasting gastric contents for tubercle bacilli. Nearly all pulmonary lesions are suspect for tuberculosis primarily. When establishing a diagnosis of tuberculosis, the laboratory should culture the sputum for tubercle bacilli, or inoculate guinea pigs, as well as examine smears. Smears of gastric contents have little value because acid-fast bacilli other than the tubercle bacilli are common.

Sputum which is to be cultured for fungi should be coughed up after the patient rinses out his mouth with water or preferably a dilute solution of alcohol and water to remove the frequent mouth contaminants. Sabouraud's mediums, or the ordinary blood agar mediums are generally used for culture. The identification of the fungus is a matter for the expert. It is difficult to culture pathogenic fungi from the stomach.

Carefully obtained samples of sputum can be studied by the Papanicolaou technic for malignant cells, which if definitely identified, are diagnostic of bronchogenic carcinoma. All patients with suggestive bronchogenic carcinoma should have a bronchoscopic examination.

A Wassermann or Kahn test of the blood should be made for every patient. Cold agglutinins are found in the serum of most patients with atypical pneumonia after the first week. Antibodies for fungus antigens are frequently present in the blood during the active stages of the infection.

Bronchoscopic examination is a highly specialized technic which should be done only by the expert. It is used to secure biopsy sections, to observe the lumen of the bronchi, and to aspirate bronchial secretions. It can be done a few days after hemoptysis; it is used freely in patients with any stage of pulmonary tuberculosis, and age is not a factor. A seriously ill patient should not,

as a rule, undergo bronchoscopic examination.

The bronchogram, or roentgenogram made after the instillation of radiopaque oil, usually iodized oil, into the bronchial tree, is used in the diagnosis of bronchiectasis. Iodized oil, which may be retained for long periods, may obscure lesions or simulate disease in a normal lung.

It is occasionally recommended that streptomycin be given to a patient who has an undiagnosed lesion of the chest. If, under this treatment, the lesion improves in two or three months, this suggests that it is tuberculous in nature. Its use in this manner has little to commend it.

Pneumoperitoneum and pneumothorax are generally used as therapeutic measures. A pneumoperitoneum will show the position of the diaphragm. It will also show whether a lesion at the base of the lung is above or below the diaphragm. Pneumothorax has been used to delineate a pulmonary lesion but it is rarely used for this purpose now.

Fluoroscopic examination of the esophagus, posterior mediastinum, and stomach while the patient swallows a barium suspension can give important information especially when diaphragmatic hernia is present.

Thickened pleura and pleural fluid are often indistinguishable when the above diagnostic procedures are used. If fluid is present, it generally can be found with a needle and should be cultured for the tubercle bacillus and other organisms. With the development of the cytologic technic for the detection of bronchogenic carcinoma, there is little need for needle biopsy of chest tumors.

The Valsalva procedure and the angiocardiogram are mentioned only for the sake of completeness. Both are used to detect an arteriovenous shunt in the lungs although the angiocardiogram has other uses.

Exploratory thoracotomy is resorted to when all the previously discussed diagnostic procedures fail to determine the nature of a pulmonary lesion. The surgical procedures accomplished after the lung is entered may be simple biopsy, removal of a segment of the lung, lobectomy, or pneumonectomy, depending on the nature of the lesion and the judgment of the surgeon. The decision to explore should be made with the advice and help of the thoracic surgeon.

Note. This is the first of two abstracts dealing with the diagnostic procedures and differential diagnosis of pulmonary lesions found either on the small film used in mass roentgenography of the chest or on the diagnostic roentgenogram.

The second part of this paper will be used to prepare the June, 1951, issue of Tuberculosis Abstracts.

PERSONALS AND NEWS ITEMS

The following members of this Society attended the New Orleans Graduate Medical Assembly at New Orleans, March 5th-8th: J. R. Barnett, Charles G. Clark, and Jack Kennedy of Arkadelphia; B. E. Barlow, Dermott; W. H. Daubs, Foreman; A. J. Forestiere, Harrisburg; James Guthrie, Camden; Arthur F. Hoge, Fort Smith; Miles F. Kelly, Sheridan; Ernest King, Russellville; Charles G. Leverett, McGehee; Mac McLendon, Marianna; Ben D. Means, Little Rock; Harold J. Morris, Pine Bluff; Harry E. Murry, Texarkana; R. O. Norris, Tuckerman and W. T. Rainwater, Blytheville.

Dr. and Mrs. L. A. Whittaker, Fort Smith, spent a recent vacation at Hot Springs National Park.

Earl Parsons announces removal of his office to 1719 Broadway, Little Rock.

The following were registered at the Dallas Southern Clinical Society sessions, March 26-29th: E. G. Burt, Magnolia; Robert H. Coleman, Little Rock; A. D. Garner, Paragould; J. A. Henry, Russellville; T. H. Jones, Waldo; Fred H. Krock, Fort Smith; J. J. Monfort, Batesville; G. F. McLeod, Magnolia; C. Fletcher Watson, Little Rock, and J. B. Wharton, Sr., El Dorado.

"Practical Physical Aspects in the Use of Radioactive Cobalt 60 as a Radium Substitute" by I. Meschan, R. R. Edwards and P. J. Rosenbaum, Little Rock, appeared in the February, 1951, issue of The American Journal of Roentgenology and Radium Therapy.

A. F. Barr has moved from Cherry Valley to Forrest City where he will be associated with J. M. Roy.

D. W. Goldstein, R. G. Kramer and W. R. Brooksher conducted a diagnostic cancer clinic at Booneville March 28th under the auspices of the Logan County Medical Society and the Arkansas Division, American Cancer Society.

The following attended the San Francisco session of the American Academy of General Practice: J. G. Gladden, Harrison; L. H. McDaniel, Tyronza; Fount Richardson, Fayetteville; R. B. Robins, Camden, and G. R. Siegel, Clarksville.

The following were registered at the Saint Louis session of the American College of Physicians: Joe H. Hardin, Little Rock; E. Z. Hornberger, Fort

Smith; J. Ken Thompson, Fort Smith; Euclid M. Smith, Hot Springs National Park; W. C. Corwin, Fayetteville; H. E. Leming, Fayetteville; L. D. Massey, Osceola; A. A. Blair, Fort Smith; Chas. T. Chamberlain, Fort Smith; Frank M. Adams, Hot Springs National Park; E. Driver Rowland, Hot Springs National Park; P. G. Alamaden, Little Rock; Dan H. Autry, Little Rock; James R. Hughes, Little Rock; O. C. Melson, Little Rock; B. B. Wells, Little Rock, and S. M. Wilson, Rogers.

R. B. Robins, Camden, addressed the Southeastern Surgical Congress at Hollywood, Florida, April 12th on "Medicine's First Year of Grace."

D. W. Goldstein and W. R. Brooksher, Fort Smith, conducted a diagnostic cancer clinic at Paris April 20th under the auspices of the Logan County Medical Society and the Arkansas Division, American Cancer Society.

J. W. Branch, Hope, recently took three weeks postgraduate work in surgery at Cook County Hospital, Chicago.

R. E. Schirmer, Fort Smith, and Alan G. Cazort, Little Rock, attended the Southwest Allergy Forum in San Antonio during April.

Dr. and Mrs. Hoyt Allen, Little Rock, spent a recent vacation in Mobile, Biloxi and Natchez.

J. R. Sloan and E. H. Abington were recently awarded Fifty-Year pins by the Beebe Masonic lodge.

Daniel H. Autry, Little Rock, was elected a Fellow of the American College of Physicians at the recent Saint Louis session.

Fred H. Krock and Thos. P. Foltz have been elected directors of Sparks Memorial Hospital at Fort Smith.

John T. Herron, Little Rock, has been elected new State Health Officer of the Arkansas State Board of Health.

PROCEEDINGS OF SOCIETIES

The Arkansas Chapter, American Academy of General Practice, met at the Marion Hotel, Little Rock, April 22nd, for the following program: "The Future of the GP," W. C. Alvarez, Chicago; "Society's Challenge to Modern Medicine," John R. Bender, Winston-Salem; "The Acute Abdomen," Phil Torek, Chicago. A banquet with installation of officers followed: President, M. D. McClain, Little Rock; President-elect, H. E. Murry, Texarkana; Vice-president, C. R. Ellis, Malvern, and Secretary-Treasurer, Fount Richardson, Fayetteville.

A meeting of the Tri-County Medical Society, including Clark, Nevada and Hempstead Counties, was held at the Barlow Hotel in Hope, Arkansas, March 27, with Dr. Gilbert Dean discussing "Surgical Aspects of Gall Bladder Disease."

Craighead-Poinsett County Medical Society met at Jonesboro April 4th with the following scientific program: "Recent Advances in Urology," James Headstream and "Management of Pruritis," Marion Craig, both of Little Rock.

The Sebastian County Medical Society honored Earle H. Hunt, President, Arkansas Medical Society, in banquet session at Fort Smith April 11th.

A postgraduate course in radiology for general practitioners was held at the University of Arkansas School of Medicine April 2nd and 3rd with the following program: "Fundamentals of Radiography," D. A. Rhinehart, Little Rock; "Dark Room Techniques," Mr. Robert Eaton, Dupont Company, Memphis; "Presentation of Problem Films," Col. Robert Ramsay, Army and Navy General Hospital; "Qualities of the Roentgenogram," George C. Burton, El Dorado; "Radiography of the Upper Extremity and Skull," C. H. Frank and C. P. Klein, Texarkana; "Radiography of the Lower Extremity, Spine and Pelvis," Jos. D. Calhoun, Little Rock; "Radiography of the Chest and Cardiovascular System,"

Luncheon was served by Mrs. Hundley and Mrs. Stern, assistant hostess. Annual reports were presented.

Ed F. Gray, Little Rock; "Radiography of the Abdomen and Urinary Tract," C. S. Pool, Fort Roots Veterans Hospital; "Radiography of the Gastrointestinal and Biliary Tracts," E. A. Mendelsohn, Fort Smith; "Film Interpretation," E. S. Kerekes, Little Rock; "Principles of Fluoroscopy and Protection from X-ray Irradiation," Wm. J. Rhinehart, Little Rock, and "Discussion of Some General Aspects of Radiotherapy," Joseph Norton, Little Rock.

The Pulaski County Medical Society was addressed April 2nd by Mr. Eugene Warren on

"Political Observations of Interest to the Medical Society" and by H. D. McClain, "The Present Status of the General Practitioner of Medicine."

Ed F. Gray, Secretary.

WOMAN'S AUXILIARY

The Auxiliary to the Garland County Medical Society met with the doctors for dinner March 30 honoring them on Doctor's Day.

The dinner was held at the Park Hotel with a cocktail hour on the sun deck preceding the dinner. Each honored guest was presented with a red carnation upon arrival.

Mrs. Bob Atkinson for the Doctor's Day Committee read a telegram during the dinner from Miss Regina Kaplan commemorating the Doctors on their day of days.

Mrs. E. K. Clardy, Secretary.

Mrs. J. Clyde Hart, Jr., was installed as president of the Woman's Auxiliary of the Jefferson County Medical Society Friday at a meeting in the home of Mrs. Louis K. Hundley.

Officers installed were Mrs. John K. Walker, President-elect; Mrs. George V. Talbot, Vice-President; Mrs. R. E. Glasscock, Secretary; Mrs. T. J. Cunningham, Jr., Treasurer; Mrs. James T. Rhyne, publicity secretary; Mrs. W. H. Bruce, historian; and Mrs. Howard S. Stern, parliamentarian.

Committee chairmen announced by Mrs. Hart were: Program, Mrs. Walker; public relations, Mrs. Talbot; education and public health, Mrs. Stern; cancer control, Mrs. Haymes; physical health, Mrs. J. S. Spillyards; membership, Mrs. R. D. Dickins; finance, Mrs. A. R. Russell; telephone, Mrs. Charles W. Anderson; hospitality, Mrs. Arthur Fowler, Jr.; civil defense, Mrs. Hundley; Doctor's Day, Mrs. Ross Maynard; and philanthropy, Mrs. Bruce.

The Monroe County Medical Auxiliary met March 14 in Clarendon with Mrs. Ben Pupsta as hostess.

Reports were given on our year's work. The Cancer Campaign in April was stressed. All members were urged to attend the State Meeting April 23-25 in Little Rock.

Election of new officers will be held April 3 at Mrs. E. D. McKnight's home in Brinkley.

Mrs. E. D. McKnight.

The Monroe County Medical Auxiliary met in regular session Wednesday, April 4, at the home of the President, Mrs. E. D. McKnight, Brinkley. Mrs. Dalton gave an interesting report of the year's work.

The following officers were elected for the year 1951-52:

President—Mrs. E. D. McKnight, Brinkley.

Vice-President—Mrs. L. W. Stout, Brinkley.

Secretary-Treasurer—Mrs. M. L. Dalton, Brinkley.

Publicity Secretary — Mrs. C. H. McKnight, Brinkley.

Committee Chairmen: Doctor's Day, Mrs. L. W. Stout, Brinkley; program, Mrs. J. P. Williams, Brinkley; nurse recruitment, Mrs. W. L. Walker, Brinkley; cancer, Mrs. B. F. Pupsta, Clarendon; bulletin, Mrs. M. L. Dalton, Brinkley; funds, Mrs. Herd Stone, Holly Grove; advisor, Dr. E. D. McKnight, Brinkley.

After refreshments the meeting adjourned to meet in Holly Grove with Mrs. Stone on June 6.

Mrs. E. D. McKnight, President.

The Auxiliary to the Howard-Pike County Medical Society met in the ladies' lounge at the Howard County Memorial Hospital March 8.

Mrs. Edwin Dildy, president, presided during the business meeting. Officers for the coming year were elected.

President—Mrs. Ed Hopkins.

Vice-President—Mrs. J. S. Hopkins.

Secretary-Treasurer—Mrs. Marion Mabry.

Plans were made for a Doctor's Day Anniversary which will be held on March 30, in celebration of Doctor's Day. A committee of two, Mrs. A. W. Hale and Mrs. H. H. Holt, was named to be in charge of arrangements for the celebration.

After the business session the Auxiliary joined the doctors for a social hour.

Mrs. J. S. Hopkins.

Dr. and Mrs. Ed G. Hopkins entertained members of the Howard-Pike Medical Society and the Auxiliary at their home on North Fourth, Friday, March 30.

The occasion was the annual celebration of Doctor's Day, set aside in 1934 in honor of Dr. Crawford Long. In keeping with the custom, Nashville and Howard-Pike physicians wore a red carnation, the official flower, on Friday.

Spring flowers in varicolored arrangements were placed throughout the living room, completing the artistic effect.

The hostess served a dessert plate to her guests, who were: Dr. and Mrs. H. H. Holt, Dr. and Mrs. J. G. Waldrop, Dr. and Mrs. Edwin Dildy, Mrs. Nina Dildy, Mrs. J. S. Hopkins, Mrs. D. A. Hutchinson, Mrs. William Gibson, Dr. A. W. Hale, Dr. and Mrs. Marion Mabry, Mr. and Mrs. John Warner, Dr. and Mrs. J. W. Scoggin and Dr. and Mrs. William Jones of Glenwood.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

THE COUNCIL URGES SUPPORT OF JOURNAL ADVERTISERS

The Woman's Auxiliary to the Arkansas County Medical Society honored physicians in the county March 13th with a dinner at the Riceland Hotel, Stuttgart.

Mrs. Milton John, Doctors' Day Chairman, welcomed physicians and outlined the historical background in regard to the commemoration of Doctors' Day.

A physician's medical bag filled with red carnations set the decoration keynote, with miniature bags containing red candies marking the places. The red carnation is the organization's official flower.

Mr. Alvin Ehrensing showed a film, "Prairie Wings," and Miss Evelyn Horst rendered a musical program during the dinner hour.

Mrs. T. S. Van Duyn closed the program with a reading of "The Physician's Prayer."

Mrs. Milton John, Secretary.

The Medical Auxiliary to the Boone County Medical Society was organized and installed on February 7, 1951, with eight charter members. Mrs. Warren Riley, State President, installed the following officers: President, Mrs. Ulys Jackson; Vice-President, Mrs. Ross Fowler; Secretary, Mrs. O. B. McCoy; Treasurer, Mrs. W. H. Breit; Historian, Mrs. H. V. Kirby, all of Harrison, Arkansas.

The Jefferson County Medical Auxiliary met March 2 at the Davis Hospital. Mrs. Howard S. Stern, President, presided at the meeting. The following gave reports: Mrs. E. C. McMullen reported on Nurse Recruitment. Mrs. George Talbot gave a financial report from the Benefit Style Show and Tea.

Mrs. Stern was appointed representative from the Auxiliary for the newly established Davis Hospital for indigent patients.

The following members were nominated for 1951-52:

President, Mrs. Clyde J. Hart; President-Elect, Mrs. John K. Walker; Vice-President, Mrs. George Talbot; Secretary, Mrs. Earl Glasscock; Treasurer, Mrs. T. J. Cunningham, Jr.; Parliamentarian, Mrs. Howard S. Stern; Publicity, Mrs. James T. Rhyne; Historian, Mrs. W. H. Bruce.

Plans were made to observe Doctor's Day on March 28. At the close of the meeting, a film, "Make Mine Freedom" was shown.

Mrs. T. J. Cunningham, Jr.

The Southeast Arkansas Medical Auxiliary met in February with six members present. The following officers were elected for the year 1951-52:

Mrs. M. C. Crandall, Wilmot, President.

Mrs. R. L. McDonald, Eudora, Vice-President.

Mrs. Van C. Binns, Monticello, Secretary-Treasurer.

Mrs. Van C. Binns.

Haddon Hall will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, June 11-15, 1951, at Atlantic City. Requests for reservations should be sent **immediately** to Dr. Robert A. Bradley, Chairman, A.M.A. Housing Bureau, 16 Central Pier, Atlantic City.

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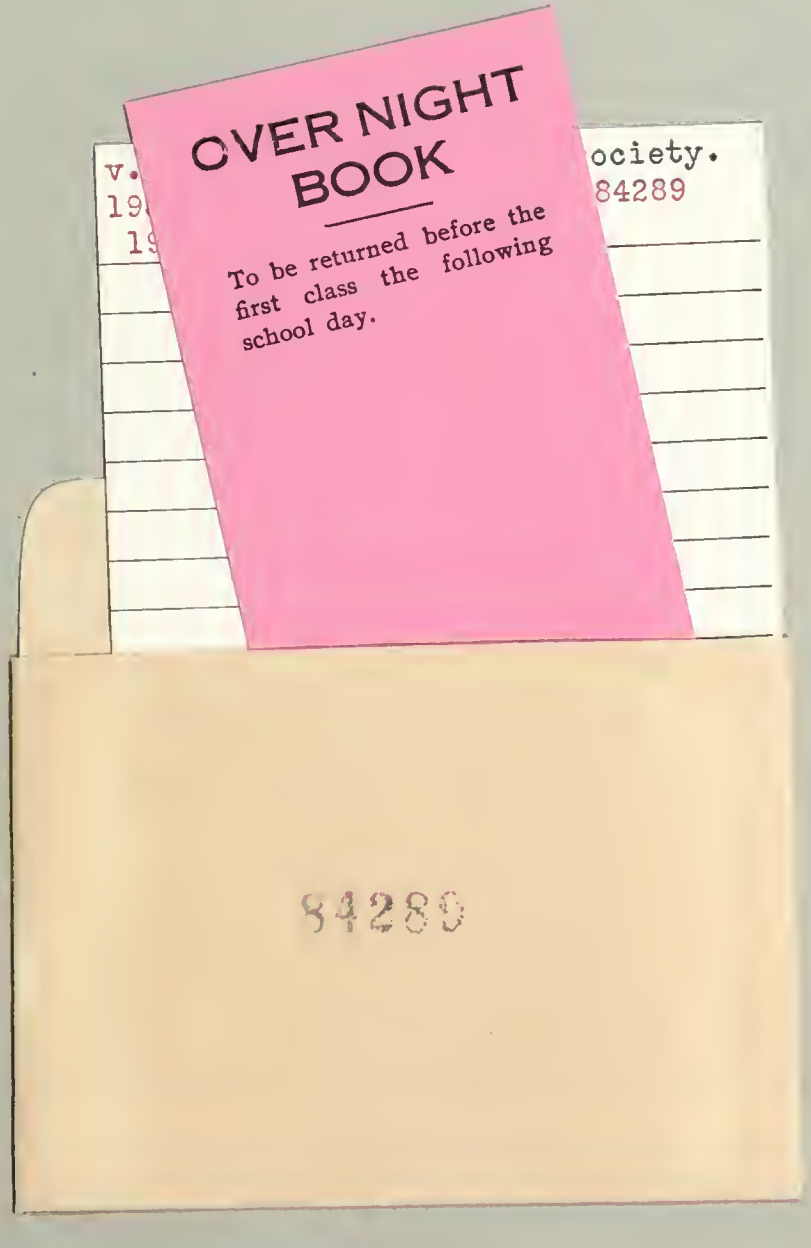
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